

**Challenging heteronormativity in drug policy and practice:  
Exploring the support needs of queer women  
who experience problematic substance use**

By

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BSW, University of Victoria, 2005

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## Abstract

Queer-identified women in Canada and elsewhere are underserved as a community with regard to the provision of support for drug use related problems. In order to provide much needed inclusive support services, researchers, policy makers and treatment providers must recognize *and act on* the interface of oppression with substance use in populations of queer women. The homophobia and heterosexism endemic to our society is an issue that necessitates the exploration, development, and inclusion of responsive policies and services for queer women who seek - or desire to seek - support for problematic substance use. This research study explores the support needs of queer-identified women who experience difficulties as a result of drug use. Through qualitative, interview-based research, my inquiry examines responses to the question: What are the support needs of women who are impacted by the confluence of heteronormativity *and* problematic drug use? Data are derived from nine, semi-structured in-depth interviews with women in the Vancouver Island and Lower Mainland areas of British Columbia. The methodological framework incorporates a critical feminist approach. A thematic analysis technique was utilized to analyse the interviews, with data categorized into three primary themes of *discrimination, resistance, and support*. Findings indicate that queer women require distinct support services for problematic substance use issues in an effort to redress systemic heteronormativity.

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# *Chapter 1*

## *INTRODUCTION*

Queer<sup>1</sup>-identified women in Canada and elsewhere are underserved as a community with regard to the provision of support for drug use related problems (Corliss et al., 2006; Dean et al., 2000; Doctor, 2004; Matthews et al., 2005). In order to provide much needed inclusive support services, researchers, policy makers and treatment providers must recognize *and act on* the interface of oppression with substance use in populations of queer women. The homophobia and heterosexism endemic to our society is an issue that necessitates the exploration, development, and inclusion of responsive services for queer women who seek - or desire to seek - support for problematic substance<sup>2</sup> use. This research study explores the support needs of queer-identified women who experience such issues. Through qualitative, interview-based research, my inquiry examines responses to the question: What are the support needs of women who are impacted by the confluence of heteronormativity<sup>3</sup> *and* problematic drug use?

### *Research subject*

Current research examining substance use and addiction is increasingly addressing the gender-specific needs of women with alcohol and other drug issues (Grella, 2008; Harrison & Ingber, 2004; Sutherland et al., 2009). Gender-specific

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<sup>1</sup> When I use the term “queer” I refer to such identity labels as: lesbians; bisexual women; persons whose gender identity is not the same as their biological sex; sexual minority women; two-spirits as articulated in some Aboriginal traditions; and women who are otherwise non-exclusively heterosexually identified.

<sup>2</sup> I use the term “substance” interchangeably with “drug” to include alcohol and other psychoactive drugs. It may be of note that none of the participants discussed their use of nicotine or tobacco products.

<sup>3</sup> An assumption that: considers heterosexuality the only normal and natural sexual orientation; a belief that people exclusively assume two distinct categories of male and female; and that each gender has natural roles in life.

responses to substance use problems are also increasingly cultivated by health-related initiatives (BC Centre of Excellence for Women's Health, 2005; Grella, 2008; Dell & Poole, 2009). Further, societal discrimination against marginalized groups is recognized as a factor that correlates with the problematic use of alcohol and other drugs (Gillespie & Blackwell, 2009; Hughes & Eliason, 2002; Weber, 2008). However, the particular needs of queer women who experience problematic substance use continue to be inadequately addressed by social service and health care policy<sup>4</sup> and practice as evidenced by a lack of involvement by sexual minority women in available support services (Corliss et al., 2006; Doctor, 2004; MacFarlane, 2003). Accordingly, queer women in Canada and elsewhere continue to be underserved as a community with regard to the delivery of support services for drug-use related problems.

Policy and practice in the field of drug use and addiction have placed increasing emphasis on *diversity* in the design of support services. However, an examination of available literature in the area of substance use and addiction makes it evident that women of diverse *sexuality* are not adequately conferred with in the development of program formation for substance use concerns (Daley, 2003; Dean et al., 2000; Doctor, 2004; Hughes & Wilsnack, 1997). Further, the existing literature does not sufficiently document the experiences of queer women – experiences that may effectively identify the specificities of their support needs. My qualitative research addresses this absence of experiential knowledge of queer women by foregrounding the support needs identified by research participants – queer women who have sought (or who may want to seek) help for substance-use problems.

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<sup>4</sup> I view most support practices/services in the social and health care fields as stemming from policy, formally or informally.

## ***Context of research***

In this thesis I illuminate the necessity for responsive policy that may lead to programming answering to the distinct needs of queer women who experience problematic substance use. My study is not a policy analysis, nor is it an exploration of current practices regarding drug support services. Specific policy concerning support for problematic substance use that recognizes the distinct needs of my subject group is largely absent. There is a lack of formal and/or informal policy and programming/practices stemming from such policy at governmental and non-governmental organizations. It is a goal of this study to provide opportunities for queer women – those most impacted by both the absence and presence of such policies and practices – to voice what they would like to see in the way of supports for problematic substance use.

In observing, studying, working, and participating in various support settings/programs for problematic drug use, I have noticed that the distinct concerns of queer women often go unaddressed. In settings where the assumption of heterosexuality in society is addressed, and subsequent substance use support paradigms account for heterosexism and homophobia in the lives of affected persons, queer women sometimes feel (and are) more included in the services. I make this statement based on personal experience as a queer woman who has received support and treatment for problematic drug use, as a clinician in mental health and addictions for a provincial health authority, and as a former service provider in a women's residential drug treatment facility that practices inclusion of *some* queer identities in its programming. From these experiences, I have observed that even in inclusive settings - such as the above mentioned women's

residential drug treatment facility - queer women may still not feel comfortable or safe bringing forward their experiences or concerns related to marginalization and oppression, or to disclose their sexual identity.

I must note from the outset that I value inclusive services for *all* systemically marginalized peoples, not exclusively queer women. Oppression relating to race, economic status, and ability, among other social locations, interlock (Fellows & Razack, 1998) with gender and factor into women's problematic use of substances (Harrison & Ingber, 2004). In addition, many queer-identified people – gay, intersex, two-spirit, and gender variant among them – experience the effects of homophobia and transphobia in concert with issues of substance use (Doctor, 2004). However, a discussion of the inclusion of the broader queer communities in substance use policy and practice is beyond the scope of this project. Thus, I have chosen to take up inclusion for queer women who experience problematic substance use as a manageable point of entry for this Master's-level research. The complexities of identity and interconnectivity of oppressions is a more extensive discussion than I am able to articulate at this time. As such, I do not claim what I've presented as a definitive dialogue. Rather, I acknowledge that the complexities exist.

### ***Social factors shaping drug use***

Not all women impacted by homophobia and heterosexism identify as queer, lesbian, or bisexual. An accurate estimate of the number of women whose identity is *not* exclusively heterosexual is not known, and will never be determined while pervasive heterosexism and homophobia exist in our societies. As long as society privileges heterosexuality, we will be unable to accurately quantitatively measure sexuality.

Quantifying sexuality is not a purpose of this study; my aim in mentioning this is purely contextual. Many people impacted by heteronormativity are not identified as non-exclusively heterosexual. How a woman describes her sexual identity may also change over time. Indeed, sexuality may be a fluid state for many people - or would be if views regarding sexuality were unencumbered by moral and social judgment. In addition, how one labels one's identity may not match one's sexual *behaviour* or actions (Dolan, 2005). Hence, women who identify as heterosexual may engage in sexual practice with other women. Because of the ubiquitous nature of heteronormativity - and its hegemonic effect of normalizing the category of heterosexual (versus the "abnormal" homosexual) - many women feel they have no choice but to identify as exclusively heterosexual. Thus, for innumerable women, internalized homophobia stemming from structural oppression, and the strain of living a life denying at least *some* aspect of their sexuality, may impact their use of alcohol and other drugs (Igartua, Gill, & Montoro, 2003; Weber, 2008). Though such women may *not* acknowledge their non-exclusively heterosexual feelings or identity, they may nonetheless be impacted by internalized homophobia. To summarize, it is the experience of oppression, *not* queer identity, which may increase the risk of negative substance use (Doctor, 2004).

It is important to note that the group that I refer to as queer women is a diverse population with regard to such factors as gender and sexual identity, race, age, ability, education, and socioeconomic status. It is this interlocking nature of oppression that creates such complexity (Smith, 1999). That is, all of the women in my study are impacted by heterosexism and homophobia, while only some are directly subjected to racism and transphobia, for example. Indeed, some participants may be impacted by

homonormativity<sup>5</sup> (Duggan, 2003), as some queer and transgender identities may not be included in lesbian space. Further, the punitive response of the judicial system additionally influences the impact of certain drugs for some people, particularly poor women and women of colour (Boyd, 2004). This means that some of the participants in my study who use/have used illicit drugs, for instance, are impacted by the illegality of those drugs and the disciplinary repercussions of what it means to ingest such substances in Canada.

Much of mainstream treatment programming does not take into account the social influences that may factor into a person's use of drugs, particularly that of multi-marginalized women. Boyd (2004) states: "identified social problems such as unemployment, addiction, and poverty are increasingly viewed as mental-health issues rather than structural issues related to globalization, and to race, class, and gender inequality" (p. 197). Queer women who use drugs suffer heightened discrimination, and oppression related to sexuality additionally factors into the context of peoples' use of drugs. (Kerby, Wilson, Nicholson & White, 2005). Effective treatment efforts must minimally recognize that *community* has a role to play in the resistance of oppressed peoples; thus, service providers may act as referral agents in connecting queer women to appropriate queer community services and supports.

It is important to note that an individual's use of drugs may not be static. A person may go through a period of time when drug use creates serious problems, perhaps due to situational stressors or exposure to particular environments. For some (problematic) substance users, the "set and setting" play an important factor in drug use

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<sup>5</sup> Lesbian, bisexual, gay, transgender, and queer peoples who assimilate or mimic heteronormative standards of gender identity and presentation are often deemed most worthy of receiving rights. Transgender and variant queer identities may experience homonormativity through exclusion.

(Boyd, 2001; Boyd, 2004; Duff, 2008; Zinberg, 1984, cited in Reinarman & Levine, 1997). Thus, behaviours related to, and effects of, drugs may depend largely on the mindset and expectations of the user, and on the social setting or environment of use.

Consequences of drug use may also differ according to the actual substance consumed. For example, alcohol and heroin are two drugs with very different consequences of use, though both are central nervous system depressants. In Canada, alcohol is legal for adults to use, whereas heroin – outside of rarely prescribed use for palliative care purposes – is illegal. The recreational use of alcohol in society is normalized (and even promoted) while heroin use is heavily stigmatized. Again, using these two drugs as an example, the problematic health effects of alcohol far outweigh that of heroin in Canadian society (Rehm et al., 2006), which is incongruent with their differential treatment both legally and morally. Thus, regulation, stigma, health and social effects vary in relation to different drugs.

Drug *regulation* predominantly impacts certain users. Particularly targeted are poor and racialized women and women who are seen as transgressing prescribed gender and maternal roles (Boyd, 2004); generally speaking, queer women are among their number. The differential treatment of women who use drugs may be viewed within a rich contextual and historical landscape that has been ongoing since at least the Middle Ages (Boyd, 2004). The social control of women who use drugs, regulation of reproductive capacity, and the heightened governance of poor women and women of colour all factor into society's punitive response (Boyd, 2004). Upper and middle-class white women are used as a benchmark of what is considered "normal" for women in our society,

specifically white women who are in heterosexual relationships and who do not use illegal drugs.

The illegality of certain drugs revolves around historical issues of power and dominance. The “war on drugs” movement has had the effect of increasing punitive responses such as incarceration, while doing little to reduce drug use (Chriss, 2002; Transform Drug Policy Foundation, 2009; Urban Health Research Initiative, 2009). However, the *illegal* status of certain drugs alters people’s relationship with the drug, dramatically increasing the dangers associated with use (Boyd, 2004).

### ***The importance of harm reduction***

Much of the discourse surrounding substance use in society flows into two streams: legal and medical. Both streams of understanding are heavily influenced by a moralizing view of drug use. Boyd (2004) explains: “The legal perspective sees the drug user as a criminal and the medical perspective is premised on ‘addiction as disease’ philosophy” (p. 155). In the legal approach, the “war on drugs” criminalizes drug users, and violates basic principles of human rights and social justice in Canada and around the world (Brocato & Wagner, 2003). The disease model, predicated on the medical/moral model, is limited to biology, and does not take into account peoples’ experiences of poverty, racism, heterosexism, transphobia/ homophobia/ biphobia, sexism and other factors that contextualize and impact peoples’ use of drugs. Further, genetic and biological understandings of addiction are highly contested (Alexander, 2001; Boyd, 2004; Reinerman & Levine, 1997; Reinerman, 2005). Drug services that centre their interventions on the disease model largely view abstinence as the “cure” to a “disease”. Problematic drug use is perceived as pathology, and thus users are viewed as diseased.

In creating and developing drug policies and practices, harm reduction strategies must play a vital role. Until the 1980s, abstinence from drugs was the only treatment option open to people with problematic substance use issues. For those who failed to comply, further marginalization occurred. Today abstinence remains a hallmark of what is known as the *recovery* movement (Rapping, 1996). Perspectives on abstinence-based services began to shift with the emergence of harm reduction as a movement in the mid-1980s.

A central feature of harm reduction philosophy is to mitigate the ill effects associated with substance use, both for the user and for society as a whole. Abstinence is considered one treatment option among many that are offered by harm reduction service providers. Harm reduction offers a broader array of services and differs theoretically from abstinence-based recovery programs. Advocates adhering to the principles of harm reduction recognize that abstinence may not be achievable or desirable by individuals who experience drug use-related problems. Thus, reduction of harm, diversity of services, priority of needs, and stabilization rather than abstinence alone, are central to harm reduction philosophy (Boyd, 1999; Boyd, 2004; Boyd, 2008; Chriss, 2002; Riley & O'Hare, 1998).

In practice, abstinence-based programming may be more popular than pragmatic among current support offerings for problematic substance use, although it certainly makes sense in the design of *some* programs. Abstinence may be an unrealistic and even undesirable state for many drug users, though it may functionally be viewed as one end of the harm reduction spectrum. It is crucial that services be harm-reduction based, with supports offered at low enough thresholds to assist anyone who asks or is in need of

support. Harm reduction as a philosophy is based on a combination of common sense, humanity, inclusion, and social justice, and has as its priority a decrease in the negative consequences of drug use, both for the individual user and for society as a whole (Riley & O'Hare, 1998). However, even with the establishment of harm reduction practices, the inclusion of marginalized queer peoples may still prove elusive.

### ***Upcoming chapters***

Chapter 2 of this thesis is a review of the empirical literature informing the subject of my thesis topic: the self-described support needs of queer women who experience substance use problems. Three trajectories of research in particular are explored for this study: *prevalence* of drug use in the queer communities; *distinct substance use support needs* of queer peoples; and (under) *utilization of existing support services* by the subject population. The goal of this review is to highlight and summarize recent empirical research that has been conducted within the above three trajectories relevant to my study topic. The literature review additionally serves to identify how my original research fills a gap in the current knowledge of what is known about support for queer women who experience problematic drug use.

Chapter 3 is a discussion of the methodological and conceptual frameworks shaping my research study. In this section, I discuss why a *critical feminist inquiry* is important as the methodological framework for my study, the qualitative design of the research, ethical considerations, and the use of semi-structured interviews as the method of gathering data. Chapter 3 also offers the conceptual framework of my research that unfolds with the presentation of theoretical lenses that inform my research question: specifically feminist, queer, poststructural, critical social, and Foucauldian theories. I

draw from writers working within these theoretical frameworks to aid in the exploration of the *social factors* that may impact the lives of queer women, and subsequently interlock with their experiences of problematic drug use.

The included theoretical analyses of social oppression are intended to provide a context for, and highlight the complexity of, inclusion of and for queer communities in the development of drug policy and practice. Specifically, I examine the concept of heterosexual hegemony<sup>6</sup>, and how this oppressive construction moves through the forces of heterosexism and heteronormativity (Daley, 2003). Based on my current understanding, I believe that the practice of providing inclusive support services to queer women is not a simple and straightforward process. Rather, the process must be understood within the context of *exclusions* and “disciplinary techniques” (Faith, 1994, p. 10) that impact marginalized groups. Implications of these disciplines and exclusions will be made explicit through a discussion of the manifold oppression endured by the subject population: oppressions grounded, in part, by an historical legacy that pathologizes both addicts and queers.

The nucleus of this research study emerges in Chapters 4 and 5 with analysis of data<sup>7</sup> collected from nine interviews. Transcripts of the interviews were coded by means of microanalysis techniques borrowed from grounded theory methods (Strauss & Corbin, 1998). Findings are discussed according to three primary themes emergent in the research

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<sup>6</sup> For the purposes of this paper I define heterosexual *hegemony* (Gramsci, 1971) as the ways in which the dominant group, in this case heterosexuals, successfully disseminate dominant social constructions as being common sense, normative or universal. Therefore, heterosexual hegemony supposes that heterosexuality is part of a natural order.

<sup>7</sup> I utilize the word “data” with some awareness: it is a term that has historically been used in positivist research and can denote a certain sterility, or objective detachment, from the voices of participants. In this document the term is used with respect and appreciation to the participants, and refers to quotations selected from the interviews for inclusion in the thesis.

data: *discrimination*, *resistance*, and *support*. Discussions of the data are based on these three subject areas and several attendant subcategories.

In the final chapter, I propose recommendations based on the research findings, conclusions that have been reached through this study, and potential areas for further research that may be explored as a result of contemplating the complete process.

## *Chapter 2*

### *REVIEW OF THE LITERATURE*

In order to provide a deeper understanding into the background of my research, a concise review of the empirical literature is presented in this chapter that pertains to the subject of support for queer women who experience problematic drug use. In particular, three categories of literature are delineated, that address: *prevalence* of drug use in the queer communities; *distinct substance use support needs* of queer peoples; and (under) *utilization of existing support services* by the subject population. These categories are useful in my examination of the data related to the primary theme of *support*. Theoretical literature linked to *discrimination* and *resistance* - the other two concepts intrinsic to my data analysis - will be discussed in the subsequent methodology chapter of this document.

I have been writing and conducting library and database searches in the subject area of queer peoples and substance use for the past eight years, throughout my undergraduate degree and into this fourth year of graduate school. From the outset it must be mentioned that there is no study that I could find in my search of academic databases, published texts, or peer-reviewed journals that specifically focuses on in-depth interviews with queer women regarding their self-defined support needs for problematic substance use. Thus, there has been no evidence-based literature available for review that closely compares to my research. This troubling discovery - or lack of discovery - alone provided ample justification for my study.

#### *Prevalence*

Following my examination of the literature related to the subject topic, it is evident that much of the focus rests on *prevalence* of substance use in gay, lesbian,

bisexual, queer, and transgender communities (Doctor, 2004; Drabble & Trocki, 2005; Gillespie & Blackwell, 2009; Hughes & Eliason, 2002; Matthews, Lorah & Fenton, 2005; Parks & Hughes, 2005; Rosario, 2008; Weber, 2008). Overall, the studies conclude that rates of substance use are higher in the queer communities than in heterosexual populations. Few others contest that view, and report findings to the contrary (Amadio & Chung, 2004). What all of the studies appear to have in common is this: a hypothesis that systemic homophobia and heterosexism contribute to an individual's experience of internalized homophobia<sup>8</sup>, and result in varying degrees of substance use as a coping mechanism.

Some of the foundational studies that cite higher prevalence are dated, and have since been challenged as methodologically flawed (Amadio & Chung, 2004; Barbara, 2002; Hughes, 2003; Hughes & Eliason, 2002; Finlon, 2002). Several methodological problems are discussed including: small samples (Doctor, 2007); non-representative samples/a lack of random samples (Hughes, 2003; Hughes & Eliason, 2002); and the inflation of prevalence due to recruitment of participants in venues that promote the use of psychoactive substances (Hughes, 2003).

Researchers Tonda Hughes and Michele Eliason (2002) have written a comprehensive "state of the science" (p.264) literature review paper outlining the research on prevalence and patterns of drug use in the lesbian, gay, bisexual, and transgender (LGBT) communities prior to 2002. The review concludes that many gaps exist in the research on the interconnection of sexual identity and substance use. The authors suggest that, according to the evidence, overall problematic alcohol and other

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<sup>8</sup> Internalized homophobia occurs when an individual internalizes negative societal attitudes, thoughts or feelings regarding their non-exclusively heterosexual sexuality. This may manifest in depression, shame, guilt, self-loathing or self-destructive behaviours such as problematic drug use.

drug use has declined in the past twenty years in the LGBT populations. However, queer youth are thought to be at particular risk for heavy use of substances (Hughes & Eliason, 2002).

As will be discussed further, many complexities exist when researching people who are identified by an immutable label, particularly within marginalized or so-called hidden populations. In addition, these identity labels - such as lesbian, bisexual, transgender, and queer - though widely used, remain ambiguous. Thus, it is difficult to compare problematic substance use indicators and risk factors associated with particular identities. Definitions of what exactly constitutes problematic substance use are equally challenging. As was described in Chapter 1, “set and setting” may factor greatly into a person’s use of drugs and may vary tremendously through the life span, further complicating research in these areas. However, Rosario (2008) argues that regardless of the definition of sexual identity, prevalence rates of substance use amongst North American sexual minorities is a significant public health concern, evidenced by several studies indicating elevated use of drugs (tobacco, alcohol, and other drugs) in these populations. Research also shows fundamental differences in patterns and consequences of use (Gillespie & Blackwell, 2009; Matthews, Selvidge & Fisher, 2005). I agree with Rosario that the use of substances in the queer communities is a primary health concern, mainly because of the latter-mentioned differences in patterns/consequences of use, and not so much due to prevalence. It is the need for appropriate response to the health and social needs of sexual minorities that most interests me, regardless of numbers.

As was mentioned above, the issue of researching the queer communities as homogenous is complicated, and likewise the use of various psychoactive substances. Is

it reasonable to compare or similarly categorize, for example, quantitative research measuring the rates of alcohol use in the lesbian population (Drabble & Trocki, 2005) with a study of street drug use as a risk factor for HIV contraction amongst a population of transgender youth sex workers (Wilson et al., 2009)? In general, a relatively small body of evidence-based research has been gathered on alcohol and other drug use specific to gay and/or lesbian communities. Substance use amongst gays and lesbians is currently considered a neglected area of scientific research (Gillespie & Blackwell, 2009). Few empirical studies have focused on the bisexual and transgender populations (Doctor, 2004), so very little is known about the distinct needs and characteristics of these groups in relation to drug use (Dean et al., 2000; Hughes & Eliason, 2002; Oggins, 2002). The literature does mention that bisexuals and transgender persons may experience marginalization from *within* the gay and lesbian communities – homonormativity – in addition to pervasive societal homophobia and heterosexism (Firestein, 1996; Israel & Tarver, 1997, as cited in Hughes & Eliason, 2002, p.288). Data collected through this thesis study provides evidence of the accuracy of this supposition.

Once again, for the purposes of my inquiry I am not so concerned with prevalence per se. What interests me most is the recognition of *difference* in patterns and consequences of use amongst queer peoples as they navigate a complex world mired in systemic oppression, and that acknowledgement of such differences in experience needs to be fundamental to any supports offered for problematic drug use. For example, for queer peoples, the life experience of heterosexism and homophobia impacts their use of substances in ways that do not occur for heterosexual people. Throughout this research inquiry, my aim is to attend to difference, or distinct needs, in the interest of social justice

and service to the marginalized community of queer women who experience drug problems. However, an examination of the literature concerning prevalence is important because such studies often examine *why* queer communities may be at heightened risk for problematic substance use, and their conclusions often implicate social factors related to marginalization and oppression.

### ***Recognition of distinct support needs***

A number of research studies have explored the importance of distinct substance use treatment programs for lesbian, bisexual, and gay peoples (Amadio & Chung, 2004; Barbara, 2002; Hicks, 2000; Matthews & Selvidge, 2005). Other inquiries have included transgender populations (Doctor, 2004), or have focused solely on the needs of male to female transgender people (Oggins, 2002). Literature in this sub-category that relates most closely to my proposed research is that which has as its subject lesbian and/or bisexual women with alcohol and/or other drug issues (Bobbe, 2002; Drabble & Trocki, 2005; Finnigan & McNally, 1996; Kerby, Wilson, Nicholson & White, 2005; Matthews, Lorah & Fenton, 2005; Parks & Hughes, 2005; Pettinato, 2005; Staddon, 2005; Underhill, 1991). All of these studies generally conclude that distinct supports are needed for the subject populations. As stated above, none of this research has used a qualitative design with an interview method for the purpose of eliciting self-defined support needs of queer women with substance use problems.

Drabble and Trocki (2005) examined data from a national American survey based on a large, representative cross-section of the United States population. The authors were specifically looking at the relationship between sexual orientation and a wide range of problems resulting from substance use. Compared with exclusively heterosexual

women, complex patterns of differential use were apparent amongst the non-heterosexually identified women in the study, leading to the finding that “lesbian and bisexual-sensitive” (p. 20) prevention and treatment services are needed to meet the distinct needs of the subject population. In another quantitative study which examined age and racial/ethnic differences amongst self-identified lesbians, the authors note that more recent and less biased samples found overall lower rates of alcohol consumption in the lesbian population compared with the results of earlier studies, though patterns and rates of drinking related problems continue to persist, even at comparable rates of ingestion with heterosexual women. The findings suggest that across age and ethnic difference, lesbians continue to be an at-risk population for alcohol-related problems (Parks & Hughes, 2005).

In a recent study that synthesized the literature on sexual minority identity development and substance use as a means to cope with minority stress, the researcher used a correlation analysis to show a significant positive relationship between exposure to heterosexist events and problematic substance use (Weber, 2008). Contrasting results from another correlation analysis were found in a study of drug use and social identity within the lesbian community (Kerby et al., 2005). Findings indicated no significant relationship between “negative social identity” (p. 45), low self-esteem and substance use. The authors do observe, however, that there is limited research in the area of queer women and substance use. Additionally, women who use drugs are highly stigmatized, and being both lesbian-identified and a drug user dramatically increases the level of discrimination. Overall, the authors note that access to health care is restricted for queer women, and homophobic attitudes still exist among health and social service providers.

Perhaps it is fair to surmise that discrimination against marginalized groups may extend to lack of support for research of such groups. Hughes and Eliason (2002) note that societal stigma related to homophobia and heterosexism has been an intrinsic factor limiting the research into queer populations in general, and directly impacts funding for such research. The authors conclude that more research needs to be done that explores the impact of “minority stress” (p.288) on drug use in the queer populations. This conclusion relates to my research topic. In one of three major themes that came to light during the analysis process, data reveal how discrimination (and stresses related to oppression and discrimination) interface with participant’s use of drugs. This same data may be useful in informing practitioners and policy makers of the distinct support needs of queer women.

In sum, the literature findings highlight that queer communities face distinct issues in patterns of substance use, and challenges related to such use. Thus, it is vital to support specialized programs and affirmative treatments (Hicks, 2000). Helping services need to address the social and psychological aspects of non-heterosexual identity, not solely factors relating in general to the problematic use of substances (Barbara, 2002). Research into client satisfaction with status quo support services shows that counsellors and treatment services are not consistently affirmative toward the queer populations (Matthews & Selvidge, 2005; Matthews, Selvidge & Fisher, 2005). More on what services recipients perceive as *affirmative* will be discussed in the forthcoming results chapters.

### ***Canadian Content***

There is a paucity of related literature that has specifically Canadian content and Canadian subjects. However, there are three papers that are of note that support the

necessity of, and connect with, my research study. Ryan, Brotman and Rowe (2000), researchers from McGill University, have written on the health care needs of queer Canadians. The authors point out that queer peoples have health concerns that are common to all Canadians and have additional historical and contemporary concerns related to mistreatment by health and social services. The queer communities are not well served by mainstream drug and alcohol programs according to the authors. Lack of training among health care providers is recognized as a barrier to service. Lesbian and bisexual women's specific needs have been largely ignored in policy and service provision. The authors/researchers place the onus of responsibility with academics, educators and policy-makers for ameliorating the barriers that exist for the queer communities in accessing appropriate support for substance use problems. My research assists with filling a gap identified by the McGill research team.

The second Canadian paper I would like to mention is a report of consultations with LGBT communities, a community action research project published by the LGBT Health Association of British Columbia (MacFarlane, 2003). This research project is closely related to my proposed research, because LGBT participants are asked to *identify their needs* related to drug use. A series of community discussions with the LGBT populations in Vancouver make up the substance of the report. Of particular relevance to my research study are findings that relate to: barriers for queer people seeking or receiving services; distinct support needs of LGBT peoples; and ensuring that existing and new programs/services are sensitive to the needs of queer-identified individuals. Recommendations include developing a broad spectrum of social supports to serve the LGBT communities, both directly *and* indirectly related to drug use.

Canadian researcher and substance use treatment practitioner Farzana Doctor has written on the links between drug use, homophobia, and “coming out” (2003), and the resultant distinct treatment needs for those who seek support (2004). Doctor notes that there are many distinctive issues that treatment providers need to attend to when working with lesbian, gay, bisexual, transsexual, transgender, two-spirit, intersex, and queer people (LGBTTTIQ). Some of the issues relate to: “cultural competence” (2004, p. 356); sexual orientation and gender identity; coming out; discrimination; and internalized homophobia. Cultural competence, in this case, refers to awareness of issues distinct to queer identity, and knowledge of what that may mean for living life as a queer-identified person. The 2004 document offers a practical guide for counsellors working within the field of substance use treatment, and is provided with the caveat that LGBTTTIQ peoples have historically been underserved by substance use treatment services. In a 2007 paper, Doctor gives a review of a Toronto treatment program, which offered specialized services for lesbian, bisexual, transsexual, and transgender women. Feedback provided by the program participants notes two very important factors defending the provision of distinct treatment services for this population: safety from homophobia and transphobia; and the space to discuss distinct issues that may not be comfortably raised in a mixed group atmosphere. Data provided in Chapter 4 by participants in my study echoes these and other similar views.

### ***Utilization of support services***

A number of studies explicitly state or allude to the fact that sexual minorities may under-utilize existing support services for problematic drug use. A recent Statistics Canada report revealed that all sexual minorities had unmet health care needs at much

higher rates than heterosexually-identified Canadians, while concomitantly being described as having higher rates of substance dependence and mental health concerns (Tjepkema, 2008). Under-use of drug use support services is implied by these statistics. An American study on drug use, drug severity, and help-seeking behaviours of more than two thousand lesbian/bisexual women revealed that 16.3 percent had wanted, and did not receive, professional support/treatment for their problematic substance use (Corliss et al., 2006). This study is striking in that it took place in an area of the United States (San Francisco Bay area/Los Angeles County) that is thought to have a relatively high number of LGBT resources. The reader may then conclude that, elsewhere, the unmet need may be far greater for those who want service and do not receive it.

Clues as to how to ameliorate the problem of under-utilization of existing support services may be found in studies that explore the *attitudes* of service providers regarding queer clients. Two studies in particular are of note because they are relatively recent and are specific to addictions counsellors/substance use treatment providers. Matthews, Selvidge and Fisher (2005) found that three variables were predictive of counsellors' positive attitudes toward lesbian and gay clientele: openly gay, lesbian, or bisexual staff; positive attitudes toward lesbians and gays in general; and a non-heterosexist organizational climate. All three of these factors emerge in Chapter 4 of this study correlating with satisfaction with support for research participants in my study. Cochran, Peavy and Cauce (2007) assessed both explicit heterosexism and implicit, uncontrolled bias in forty-six treatment providers. This study similarly concluded that a biased attitude is stronger in heterosexual counsellors, and also found a higher rate of negative attitudes in counsellors with few LGBT friends. These studies provide insight into barriers that

may be faced by queer persons who present for help with substance use problems. The studies make the point that though queer persons are over-represented in support-seeking samples, counsellor training regarding distinct needs of such persons is inadequate. Overall, the studies conclude that: queer persons benefit from services that acknowledge their differential treatment in society; service providers are not adequately educated on LGBT issues despite over-representation of these communities within their clientele; more research is needed to uncover the impacts of heterosexist bias on service recipients, and may be used to inform and implement more accessible and effective supports.

In sum, the literature on the subject of support indicates a prevalence of problematic substance use in populations of queer women that is significant because it points to differences in patterns of use. Because of these differences, distinct or specialized support services are necessary to adequately attend to the needs of queer women who experience problematic drug use. Finally, the research shows that sexual minority women may under-utilize existing support services and that when status quo services are accessed, *why* the heteronormative offerings of such supports may not prove adequate.

## *Chapter 3*

### *THEORY AND METHODOLOGY*

#### *Conceptual stance*

I approached this research with an assumption that shapes the conceptual framework of my methodology. My assumption is that the lives of queer women in Canada and elsewhere are impacted by heterosexual hegemony. Hegemony may be understood as the ideal representation of the interests of a dominant or ruling group as universal interests (Marshall & Scott, 2005). A Gramscian understanding of hegemony (Allman, 1988) explains how a value system, in this case heteronormativity, serves to privilege the dominant understanding of sexuality. As will be clarified further through the confluence of the theoretical lenses underpinning my research, heterosexual hegemony *moves through* the forces of heterosexism and heteronormativity. By exploring notions related to heterosexism, heteronormativity, exclusions, pathology and normalizing practices, in this chapter I will discuss the *theoretical* literature related to the research, and examine the relevance of these concepts to my research study. The following theoretical explorations provide necessary insight into the social context of my research, information that proves vital to the interpretation and analysis of collected data.

Queer women are not recognized as a community of health service users with distinct needs apart from their heterosexual counterparts (Daley, 2003; McDonald, 2009). This lack of recognition manifests in various ways. For some queer women it may result in invisibility, for others, in hyper-visibility, by which I mean an inappropriate and inaccurate visibility based on dominant societal stereotypes (Daley, 2003). Drawing from feminist theories, queer theories, and arguments articulated by Foucault (1978, 1981,

1985, 1997), I attempt to illustrate how heterosexual hegemony acts to subjugate the experiences of queer women. Further, by placing my work under the rubric of social justice, I investigate the threads holding together the matrix of oppression in the lives of queer women that are impacted in myriad ways by heteronormativity and homophobia.

***Historical pathologizing of queer and “addict” identities***

Michel Foucault, in his various writings on the history of “the homosexual” identity, illuminates the silencing of queer identity expression as it functions through the *performance* of heteronormativity. Following Foucault’s scholarship, many academics – poststructuralists and queer theorists among them – base their explorations on his influential works. The historical medical/psychiatric discourse regarding the classification of “the homosexual” clearly pathologizes queer identities (Foucault, 1985). As O’Brien (1999) explains: “Psychiatry and medicine labelled homosexuality a perversion and gave ‘the homosexual’ a case history ...” (p.141). Throughout much of the past century, homosexuality has been officially classified and “treated” as a mental disorder. Dominant social attitudes – the normalizing vehicle of hegemony – have developed within the context of the medical/ psychiatric pathologizing of queer identities (Berkman & Zinberg, 1997; Daley, 2003; Foucault, 1978; Somerville, 2000; Taylor, 1999). Support programs for problematic drug use have likewise developed within this context, and have traditionally and contemporarily enforced and perpetuated the conditioning effects of heterosexual hegemony.

Similarly, from the 1940s to the 1960s, addiction to illegal drugs was viewed and defined as a deviant pathology, and addicts were labelled as having a deviant psychopathic personality. The psychiatric profession worked hand in hand with law

enforcement in marginalizing, pathologizing, and criminalizing peoples addicted to drugs. Particularly during the 1940s to the 1960s, queer-identified addicts were viewed by psychiatry and society as exponentially psychopathic or doubly deviant (Acker, 2002; Becker, 1963). It wasn't until the late 1960s and early 1970s that the influence of psychiatry and law enforcement lessened, to some extent due to emerging sociological perspectives from Alfred Lindesmith (1965) and Howard Becker (1963). These sociologists introduced standpoints clarifying the notion that illegal drug use *in itself* is not deviant, nor are the people who use prohibited drugs. Rather, drug use is shaped by social factors, including prohibition and policing. This perspective also evolved in part due to the explosion in recreational drug use by young people at the time who viewed their drug use as a normalized activity.

Drug use continues to be viewed as a criminal and medical problem. Indeed, “addiction” is currently and historically defined as a mental disorder by the hegemonic document, the Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition (DSM-IV), which classifies “substance use disorders” as mental illnesses (American Psychiatric Association, 1994). Women who are queer *and* who use drugs continue to be viewed as exponentially deviant, as they transgress several sites of historically prescribed norms for women in our society.

An additional legacy of this historical backdrop is the trepidation and mistrust that is experienced by queer women with regard to institutional supports. This mistrust exists for good reason, and data offered by participants in the analysis section of this document echoes this sense of wariness toward social and health care service providers. Despite more recent advances of gay/lesbian civil rights, and the removal of homosexuality from

the DSM II (Diagnostic and Statistical Manual of Mental Disorders, Second Edition, 1968) in 1973, there remain residual attitudes in the medical system and in society from this historical context (Daley, 2003; Voorhis & Wagner, 2002). As a result of this legacy, many service providers, particularly in the medical field, are influenced by the former classification of homosexuality as a mental disorder. Homophobia and heterosexism function in society in ways that result in exclusionary practices and prejudices (Ristock & Julien, 2003), reinforcing the status quo. Against this formidable backdrop, speaking out about one's queer identity becomes a powerful act of *resistance*. More common, however, is silence and internalization of societal attitudes that are perhaps viewed as "natural", given the potent conditioning effect of heterosexual hegemony. Both of these responses to heterosexual hegemony are mirrored by the participants in my study, and are thoroughly explored through analysis of themes of discrimination and resistance in Chapter 4.

All told, women who use drugs in our society are constituted as deviant, immoral, and consequently are subject to regulation in our society (Boyd, 2004). Further, heterosexuality is understood as the natural and inevitable state of the normal human condition. People who make up the "other," composed of varying gender identities and sexual orientations, are similarly subject to rejection and the label of deviance. Practices of normalization and regulation are thus evident in the aspects of society to do with both drug use and sexuality.

### ***Internalization of oppression***

Queer peoples often experience the internalization of negative attitudes that result from living in heteronormative societies (Cheng, 2003; Clare, 2001; Igartua, Gill, &

Montoro, 2003). Eli Clare (2001) writes of the intrapersonal experience of oppression coming to rest in the body: “There are so many ways oppression and social injustice can mark a body, steal a body, feed lies and poison to a body” (p.362). Further, Clare explains that the aims of social justice are very often framed as a refiguring of the *external* world. The external conditions of oppression are marked as problematic – perhaps solely responsible for social injustice. However, anti-discrimination policies and queer-inclusive programming are not always sufficient to end the silence of queer women regarding their sexual identities. Bodies internalize oppression and bear its weight (Clare, 2001). The workings of heterosexual hegemony depend on the bodies and spirits of the oppressed *learning* silence. As such, queer peoples often learn to pass as heterosexual, or at minimum remain silent under the pressures exerted by heteronormativity (O’Brien, 1999). Data provided by participants in my study mirrored various manifestations of this response that are explicated in Chapters 4 and 5 of this thesis.

Outright displays of homophobia are uncommon in present-day health and social service organizations. However, institutional heterosexism may commonly manifest in the form of “don’t ask, don’t tell”, a very powerful discourse. Often the heterosexist dialogues in social and health service settings implicitly dictate that people should be treated equally and, therefore, the *same*. What this translates into is that everyone should be viewed and treated as *heterosexual* (Chervin, Brotman, Ryan, and Mullin, 2003; McDonald & McIntyre, 2003). Thus, according to the language of heterosexual hegemony, equal means heterosexual and queer peoples are rendered invisible.

A closeted queer identity – constructed and maintained in the shadow of heterosexual hegemony – may not be the best atmosphere in which to develop a positive

sense of self (England, 1999; McDonald, 2009). To illustrate how this works, the concept of Foucault's panoptical view may be used as a metaphor for heterosexism (Davis, 1995, cited in England, 1999, p.97). The panopticon is a design for a prison that keeps inmates isolated yet in constant view of their captors from a central place of observation. Thus, prisoners do not know if and when they are being observed (Mansfield, 2000). The result is a tendency to self-regulate and self-govern. The panoptic heterosexist gaze encourages self-monitoring of queer peoples, and acts as a force that silences and isolates (England, 1999). In the face of these functions of power, silence and invisibility of queer people's identities is perhaps inevitable rather than exceptional, as will be revealed through several examples provided by my study participants, and discussed in the upcoming analyses chapters.

### ***Creating community***

Feminist standpoint theorist, Sandra Harding (1995), tells us that members of the dominant society do not have to work at creating inclusion for themselves in their histories and everyday lives. She writes: "Members of marginalized groups must *struggle* to name their own experiences *for* themselves in order to claim the subjectivity, the possibility of historical agency that is given to members of dominant groups at birth" (p.128). There is no such bequest for queer peoples. Indeed, as has been discussed above, our legacy is, at worst, one of being pathologized, maltreatment, and ostracism. At best, this history takes the form of silence and invisibility (Daley, 2003). Data presented in Chapter 4 of this document illustrate the ways that inclusion may be strategically negotiated, for what purposes, and at what costs.

Queer peoples do not have a *given* support structure and familial mentors to share in their experience of oppression. We must *build* community, find it and foster it. The isolation and enforced silence created by heterosexual hegemony often keeps queer peoples from identifying one another in public spheres. Daley (2003) elucidates: “What is not being said is loud enough to enforce silence” (p.105). As such, heteronormative assumptions enforce silence and queer people are frequently kept from the solidarity that community affords. Given Foucault’s argument about the productive character of power (1978), perhaps this is what heteronormative practice produces: an individualizing effect for all “others”. The power of community cannot be underestimated in the role it plays for the resistance of marginalized peoples. Paula Gunn Allen (1998) explains: “community is what a human being must have to be human in any sense” (p.29). Through the oppressive force of heterosexual hegemony, and consequent isolation and silence, queer peoples are often denied the strength of community in institutional/organizational spaces. However, as is discussed in upcoming chapters, respondents in this study offer ways that they have nevertheless constructed community, or are able to envision the *role* of community, in resistance to oppression.

For many people, the *practice* of silence and denial of self and queer identity takes a toll that can be seen played out in the lives of so many queer women. Thinking through the *action* of silence from a poststructural perspective, we learn to *govern* ourselves – live in the closet; remain silent and hidden – in collusion with hegemonic heterosexist forces (White & Hunt, 2000, p.93). Marginalized peoples internalize - and often believe - what the dominant group says of them (Harding, 1995). Thus, on some level, the internalization of the lies queer people are told - the lies of alleged deviance and

abnormality - are deeply embraced and facilitate the functioning of heteronormativity. Queer peoples are not seen as deserving the same voice as their binary counterparts: heterosexuals presumed to be normal and natural (Ristock & Julien, 2003). Enforced standards of normalcy, stated and unstated, form the context of silence surrounding many difficulties faced by queer women who experience problematic substance use. Indeed, these same standards inform support services for problematic drug use offered by the dominant society.

### ***Foucault and biopower***

Foucault (1997) states: “Sexuality exists at the point where body and population meet. And so it is a matter for discipline, but also a matter for regularization” (p.252). Within Foucault’s historical chronicle of a constructed and pathologized category of homosexual, and the *definition* of heterosexual in opposition to this category, a framework of “normal”/moral has been created in society (Foucault, 1978). Foucault suggests: “The norm is something that can be applied to both a body one wishes to discipline and a population one wishes to regularize” (1997, p.253). Foucault’s concept of “sexual science,” a form of power/knowledge, is based within the medical/psychiatric discourses that suggest certain (heterosexual) behaviours fall under the category of normal while others (homosexual) fall under the purview of abnormal or pathological (O’Brien, 1999). This history provides a rich backdrop for the context of my research, the effects of heterosexual hegemony on queer subjects as viewed through the lens of support for queer women who experience problematic substance use.

Power/knowledge in the form of what Foucault (1978, 1997) terms *biopower* resulted in such things as the official historical designation of homosexuality as a mental

disorder. It lives on today in the working of heteronormative silencing enforced on and through queer peoples. Ann Fausto-Sterling (1997), a contributor to the canon of knowledge known as queer theory, describes the practice of normalizing heterosexuality as working to “use the infrequent to illuminate the common. The former they call abnormal, the latter normal ... the abnormal requires management ... management means conversion to the normal” (p.245). Silence is about passing as heterosexual. Silence is an insidious product of biopower. And because of silence, queer peoples are rendered invisible, both as professionals within social and health services, *and* as service users. The social and health service professions have been constructed within the context of this history of normalizing practices. Thus, queer people have been, and are, inscribed with the label “abnormal”. Consequently, heterosexuality has been normalized at the very core of health and social service practices (O’Brien, 1999).

### ***Forging resistances***

One of the effects of “the homosexual” acquiring a history was a response of resistance by queer communities to the pathologizing of our selves and our identities (O’Brien, 1999). Foucault (1978) termed this response “reverse” discourse: “homosexuality began to speak on its own behalf, to demand that its legitimacy or ‘naturalness’ be acknowledged” (p.101). Terry (1999) also writes of this bequest: “One important effect of this process was the generation of constraints and possibilities occasioned by the label of pathology” (p.325). Brock (2003) echoes Foucault: “Where there is power there is also resistance to power” (p. 20). She offers, as one incisive example, the formation of queer politics and the growing body of knowledge that is known as queer theory. Queer identities are named and formed through the process of

building community in what may be known as acts of resistance to a heteronormative power structure. In one primary trajectory of data analysis, I foreground the resistances of women whose stories shape the substance of this research study.

bell hooks (1994) espouses: “Theory is not inherently healing, liberatory, or revolutionary. It fulfills this function only when we ask that it do so and direct our theorizing toward this end” (p.61). Queer theories - theories that act in resistance to the binary constructions of normal/abnormal, heterosexual/homosexual - question these oppositions and disturb the power relations that construct such things as the assumption of heterosexuality as a consequence of normalizing practices (Warner, 1993, cited in O’Brien, 1999, p.143). Throughout the construction of my thesis, I utilize as a viewpoint these and other such theories and concepts that seek to undo the processes of “normal”.

### ***Research design***

I chose a *qualitative* research design for my inquiry, as it stimulated a rich and descriptive exploration of my subject. I sought to gather and understand information about the subject of support for queer women with substance use problems through documenting what participants from that population had to say about their experience of this. Marshall and Rossman (1989) describe benefits of qualitative research that were congruent with my study expectations and objectives. In their view, qualitative research is a mode of investigation that “values participants’ perspectives on their worlds and seeks to discover those perspectives, that views inquiry as an interactive process between the researcher and participants, and that is primarily descriptive and relies on people’s words as the primary data” (p. 11). In harmony with a feminist approach, the qualitative design of my research study has allowed for the subjugated voices of queer women to be

heard. Incorporating qualitative research into the process of developing supports for problematic substance use can be viewed as an effective strategy to meet the needs of marginalized groups (Samson, Singh & Barua, 2001). I was interested in privileging the experiences of queer women as a *process* of social justice for this group. During the interviews, several of the participants noted that even having been *asked* to share their experiences and insight on the subject of the study proved very affirming.

*Selection criteria* included women - biologically born or self-identified - over the age of 19 years who identified as non-exclusively heterosexual, and who simultaneously recognized their drug use as problematic. Through purposive sampling (Ritchie & Lewis, 2003), I included as diverse a participant population as was possible with regard to race, age, class, and identity. Because of a strong and relatively immediate response to the call for participation for this study, I was able to choose a somewhat varied group of participants relating to the above noted diversities. This was done during short telephone conversations with potential participants to assess suitability for the study prior to setting up an interview. When queried, participants identified their sexual identity with various heterogeneous descriptors: queer woman; dyke, gay woman; butch lesbian; two-spirit; trans; lesbian; and queer. Age range was from early twenties to late fifties. I did not ask participants to self-identify ethnicity. However, two participants identified as First Nations and seven appeared of Caucasian European origin. Maximizing diversity within the participant group – though scientifically non-representative – makes important contributions to this research by possibly exposing certain interconnections between these social locations/identities and problematic use of substances.

I sought out participants at several locations in the Vancouver Island and Lower Mainland regions of British Columbia that queer women might frequent or where they were seeking support at the time of data collection. These locations included: needle exchange/safe consumption sites; queer and lesbian internet websites; substance use counselling services; university/college gay/lesbian/bisexual/transgender organizations; university listservs; and harm reduction community groups. Posters/flyers (see Appendix D) advertising my projects were posted at some of these locations and descriptions of the project appeared on various websites (see Appendix C). Snowball sampling, where participants inform other potential participants by “word of mouth,” was employed, as it is a commonly used recruitment technique for so-called difficult to reach or “hidden” populations (Faugier & Sargeant, 1997). The snowball sampling technique generated the overwhelming bulk of responses, and disrupted the hypothesis that the subject population was “hard-to-reach”. Within two weeks of disseminating information about the proposed study, I was contacted by approximately three times the number of respondents that my research could accommodate. This response was *not* anticipated, yet proved very affirming. Thus, I was able to do a brief and generalized screening of participants to generate some diversity within the sample. As an additional requirement of participation, I subjectively evaluated respondents as not in a period of crisis regarding their drug use at the time of the interview. This was done in consultation with individual participants, based on what they disclosed to me. I conducted this informal process of evaluation in a pre-interview telephone conversation with participants before formally scheduling an interview. A cell phone number and email were used as the primary methods of contact for potential participants. Once a response to the invitation to participate in the research

was received by email or telephone, I then followed up with a phone call to the potential participant, discussed the details of participation, and if appropriate, emailed out a copy of the consent form (see Appendix B) for perusal.

In one of the initial icebreaker questions asked during the interview (see Appendix A), respondents were asked how they had heard about the study. The complexity of responses fascinated me. Participants described elaborate and web-like systems of information sharing that stemmed from the initial call for participants as it was described above. The response has given me confidence that future research with these – or similar – populations might likewise generate abundant interest.

### ***Method***

The information that I gathered for my research data was collected through conducting in-depth, semi-structured, in-person interviews with nine key participants in the Vancouver Island and Lower Mainland areas of British Columbia. Shulamit Reinharz (1992) describes the interview method as a primary tool used by feminist researchers. I was fundamentally interested in how the participants in my project construct and interpret their experiences. Seidman (1998) suggests: “At the root of in-depth interviewing is an interest in understanding the experiences of other people and the meaning they make of that experience” (p. 3). Joan Scott (1992) observes that through “experience”, hegemonic understandings may be questioned when alternate views are presented.

The research of Melvina Johnson Young (1993) provides evidence that power relations in the interview process impact *what* is said and *how* it is said. I have explored the notion of how experience is thus produced by knowledge that is generated through discourse, and remained aware of this throughout my process of conducting interviews

for this study. Scott (1992) suggests that “experience” is itself contestable and “therefore political” (p. 37). This notion stood out in my mind as I contemplated ways to write of experience and its constructed nature, while concomitantly honouring “epistemic privilege” (Narayan, 1988), or the insider knowledge/lived experience of participants. In addition, the interview process warrants ongoing problematizing, as it is a performance of sorts and not without power issues (Allen & Cloyes, 2005). An intrinsic aspect of this task is the continuing deconstruction of my role as researcher and the power situated in that function (Oliver, 1990). Further, Oakley (1990) cautions the researcher against “over rapport” with participants (p. 34). Throughout the research process I was mindful that, though I may share some commonalities with participants, I remained the *researcher*.

In general, the questions forming the interview followed a logical sequence, which began with general questions designed as “icebreakers” (see Appendix A). I followed the advice of one source suggesting that the format should follow the form of a social conversation. The questions were grouped by topic, and arranged from the more general to the more specific. In addition, the questions that were perceived as least threatening - or personal - were asked first. I avoided ambiguous questions and invited the participants to seek clarity throughout the interview process. Although the research trajectory asked women questions regarding their problematic use of drugs, I did not focus solely on negative issues or lines of inquiry that might serve to reinforce to participants “what is wrong” (Smith, 1999. p. 198), or that they, or their behaviours, were in some way dysfunctional or iniquitous. Additionally, Michael Oliver’s (1990) work encouraged me to formulate the research questions so that they, in part, functioned to interrogate social structures and not solely the individual participant.

From my own perspective, the interview process itself is the one element of graduate school research that continues to draw me back time and again to the desire to conduct further research at the graduate level. Qualitative investigation utilizing the method of in-person interviews was the most exciting, dynamic, and surprising experience that I have ever had in all my years of education. It brought the concepts of co-created learning and production of knowledge alive for me. Several times during the interviews, respondents to my research alluded to or directly remarked on their perception that they were contributing to the knowledge base and/or challenging heteronormativity through participation in the study. This feedback gives me hope and belief that marginalized peoples, and researchers working within marginalized areas of interest, can shape a difference in our society.

### ***Ethical considerations***

Ethical standards for working with human subjects were in compliance with the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (1998). My research proposal was scrutinized by University of Victoria's Human Research Ethics Board (HREB), with an approximate waiting period of six weeks. It passed through the process of approval with no major revisions.

It is essential that the *anonymity* of my research participants be safeguarded: "Anonymity means that the readers of the research will be unable to identify participants by name, through the experiences being described or by location" (Kirby & McKenna, 1989, p.118). *Confidentiality* was achieved through managing the data in such a way as to prevent participants' identities from being linked to their responses. This involved the use of pseudonyms, leaving out specific facts and identifying particulars, and eliminating

exact demographic details. I changed names and left out particular identifying and geographical information in order to achieve both anonymity and confidentiality to the best of my ability. The information collected through the interviews was always secured in a locked location. Protecting participants' confidentiality was additionally vital because it could also mean ensuring that no harm comes to them because of what they disclosed in the interview (Rubin & Rubin, 1995).

Participation in the research was entirely voluntary, and participants were told that they could leave the process at any time and for any reason. All interviews were audio taped and transcribed. Further, the transcription was available for any participant to review at any time subsequent to the interview to ensure that their words were accurately recorded. However, no respondent requested this option. Participants read and signed a consent form (see Appendix B). The form included the following information: an introduction to the research; statement of the research purpose; expectations of the participant (i.e.: the interview may take up to 1.5 hours); explanation of possible risks and discomfort; assurances of anonymity and confidentiality; offer to answer any questions; option to withdraw at any time and with no explanation. The participants were given an *honorarium* in the amount of \$30.00. The interviews took place at a location of the participant's choosing. This was done because the comfort-level of the participant may help to mitigate the power imbalance that is inherent in the researcher-participant dynamic (Smith, 1999). Eventual locations for interviews included: coffee shops/cafes; participants' homes; a hotel room; and a neutral office on a university campus.

It was important to me that I achieved ethical standards meeting and exceeding those that were required by the University's HREB. As a queer-identified person, I am

aware of some of the potential risks to individuals who disclose their sexual identity in certain circumstances. Indeed, queer women who experience negative drug use are further on the margins of society, and thus it was even more important that I guarantee their anonymity (Kirby & McKenna, 1989). The possible *risks* associated with participation in this study were of an emotional nature. I was aware that it could be difficult for some people to discuss issues related to their sexuality and/or their drug use. Even though I did not *expect* to cause emotional harm through the interview process, I took some precautions in the event that someone was in distress. I had available numbers of the local crisis line in each area where interviews were conducted, and contacts for crisis counselling services. In addition, I work as a mental health/addictions clinician with marginalized peoples whose lives are characterized by frequent crisis and strife, and have additional training as a counsellor at a substance use treatment program that serves women who have experienced violence and trauma. If a participant had disclosed that they were experiencing any discomfort or stress - or if I suspected that they were - I was prepared to stop the interview. Further, I would have followed up with that participant and ensured appropriate support was received. I was also aware that, in some cases, discomfort with the interview might have been a momentary occurrence; in such an instance a participant may have wanted to stop the interview and reschedule for a later date. None of these eventualities occurred, though preparation was important in the event that discomfort or distress was created by, or manifested from, the interview process.

### ***Insider/Outsider status***

The writing of Linda Tuhiwai Smith (1999) has been instrumental in the process of thinking through my role as both an *insider* and *outsider* in the research. As a queer

woman who has experienced problematic substance use, I at times have been tempted to think of this project as “insider” research, particularly when respondents shared experiences that resonated with my own. This standpoint required that I employ constant reflexivity in the process, as well as have personal supports in place to help me with emotional challenges (Smith, 1999) that did arise on occasion. Smith also cautions that there are many locations that may situate me as an outsider in this research: for example, my education level and professional status was different from that of most respondents. I interviewed transgender, Aboriginal, and two-spirit individuals, and thus was as an outsider through identity. I do not claim an “official insider voice” (Smith, 1999), nor profess a position of authority over this research or topic (hooks, 1989). However, as an insider in many respects, it is clear to me that I am on the side of the participants (Becker, 1970), and recognize that my bias is consequently woven throughout my motivation for, and design of, this research study. My “bias” is that queer women do not have sufficient support for problematic drug use. A primary aim of this study is, in part, to shore up evidence that more distinct supports are needed.

### ***Analysis of data***

I was interested in working the data reflexively with theory that resonated with the responses of participants (Marshall & Rossman, 1989). Marshall and Rossman observe: “The researcher is guided by initial concepts and guiding hypotheses, but shifts or discards them as the data are collected and analyzed” (p. 113). As outlined in the methodology section above, my research topic was informed by theoretical explorations of power, and assumptions that pertain to social influences on my subject.

A thematic analysis technique was used to code transcripts of the interviews (Strauss & Corbin, 1998). Within qualitative research, thematic analysis is one way to comprehend and analyse participants' response to questions about their experience (Aronson, 1994). The transcripts were read over several times, and three primary themes of *discrimination*, *resistance*, and *support*, quickly became evident, as well as many subthemes attendant to these major categories. A constant comparative method (Glaser & Strauss, 1967) was utilized to develop the themes and subthemes that are presented in Chapters 4 and 5 of this document. Thorne (2000) describes this process: "this strategy involves taking one piece of data (one interview, one statement, one theme) and comparing it with all others that may be similar or different in order to develop conceptualizations of the possible relations between various pieces of data" (p. 69). I derived my themes by comparing topics related to my area of inquiry that arose in each interview with common subject matter that surfaced in two or more of the other interviews. The three primary themes and various subthemes are based on words, phrases, and key subject topics privileging the words and experiences of participants.

### ***Significance of research***

One objective of this research is to identify what queer women need in the way of support for substance use issues. I purposefully did not define what may constitute support in advance, because participants have defined their needs in such distinct ways. In order to identify the needed supports, I elicited the experiences of queer women who self-identified as having experienced problematic substance use. I have made use of critical feminist methodologies, which are advantageous for research with marginalized populations (Kirby & McKenna, 1989; Reinharz, 1992; Smith, 1987). Such approaches

provide ways to examine how current substance-use support systems, influenced by mainstream policy and practice, may in some circumstances ill-serve women in society and further marginalize some women on the basis of their sexuality.

## *Chapter 4*

### *FINDINGS: DISCRIMINATION & RESISTANCE*

*You don't feel included ... You feel like you are wrong about who you are. Like my church was totally willing to support me being a drug addict but not being homosexual, which is just totally fucked up in my head. (Maria)*

#### *DISCRIMINATION*

During the data analysis process, the subject of *discrimination* in various permutations quickly became apparent as a central theme. Each of the research participants contributed a cornucopia of information within this topic area. What began as approximately eighteen subthemes has been reduced to three interlocking categories in the interest of readability and sheer management of the volume of potentially usable data that emerged through the coding of interviews. The subthemes: *discipline and regulation*; *heteronormativity in institutional settings*; and the *importance of openness regarding sexual identity*, are included under the rubric of discrimination<sup>9</sup>.

#### *Discipline and regulation*

To begin this sub-category of discrimination, I foreground participants' remarks concerning one subtle yet particularly insidious manifestation of discipline and regulation: that of *silencing and invisibility* as a product of heteronormativity. In Chapter 3, I introduced theoretical literature that provides a backdrop for conceptualizing silence and invisibility as both: a) a response to oppression; and b) an everyday, normalized reality concerning ubiquitous heterosexism and homophobia in the lives of queer-identified subjects within society. What is at work, then, to enforce silence in such an

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<sup>9</sup> Included within my understanding of discrimination are the following phenomena, as previously discussed in the theoretical literature: homophobia; heterosexism; silencing; invisibility and hyper-visibility; isolation; assimilation; internalized homophobia.

environment? Feminist scholar, Karlene Faith (1994), writes of Foucault's inquiry into functions of exclusion:

Foucault's work illustrates that, when a group of people are separated from society, it is not a random affair. They are discerningly divided off from the population, through discursive and exclusionary exercises of sovereign power, and subjected to disciplinary techniques that classify and control them through strategic power relations (p.10).

It is referred to "discursive and exclusionary exercises" (p.10) and "disciplinary techniques" (p.10) that most intrigued me as I went about the task of analyzing the data.

In an echo of earlier discussions around aspects of Foucault's scholarship, several respondents described how heteronormativity was enacted through the *performance* of silence and consequent invisibility in the context of their everyday lives, often specific to the drug treatment milieu.

When I haven't spoken up it definitely makes me feel invisible. I also feel that probably more so with my gender identity than with my sexuality. (Shane)

They were all heterosexual treatment groups. I would come out though, once in a while, just to talk about how it was for me. But again, the inherent homophobia and how society's treating you really makes you not *want* to be honest ... (Isabel)

In the day program that I did we went through an exercise where we kind of mapped out our genealogy or our history, and our history of our family and then our history of ourselves in relationship to other people. And that included your past relationships, and so I was terrified. I was absolutely terrified! And the group that I was in - it was a group of about oh, I dunno, maybe ten women - I was terrified to come forward and say my last however many relationships had been with women. I didn't feel comfortable because I didn't know if I was going to be judged by the other women in the group, even though it was all women. I was terrified. I was like I didn't want to come out to these people, and I don't know, I don't want to have to go through like baring my own soul around my alcohol use and my history, and *then* go through outing myself as well, only to have anybody at this point think bad about me or say anything or do anything, then I totally couldn't handle it. And I was in such a huge place of fear and of not wanting to go through with it. (Danielle)

In this last statement, Danielle illustrates how the intersectionality of internalized

homophobia, and feelings of shame around her drug use, functions to further her enactment of silence and impede progress in a drug treatment setting.

Respondents spoke to the problem of silence in an atmosphere of heterosexual hegemony. In some instances, oppression is felt as more than just an *assumption* of heterosexuality; it is perceived as the only *allowable* sexuality.

I felt like everybody was talking about their relationships but I felt like I wasn't really allowed to share about mine.

Sher: Okay you weren't allowed to share about yours. How did that feel for you?

Lonely. Yeah. Lonely and not accepted. (Maria)

Nicki describes fearing homophobic violence or vilification if the silence is broken:

I do feel silenced ... it's just intimidating, and I don't know what's going to happen when I leave [group], you know. I feel like I can't speak up. I can't say anything about [non-heterosexual] sexuality or trans issues or anything like that. No, I feel just totally very uncomfortable and very threatened and shut down. In fact, that happened just on Monday. It was a co-ed group and a drop-in group and again I'm the only - oh wait, I might not have been the only queer person there. It was co-ed and these guys, you know these kind of loud mouths, you know, intimidating guys came in, and very loud and disruptive, and the f-word and this and that. I didn't share at all, not at all. And the counsellor that was running the group said that she could, you know, physically watch me shut down. All the doors shut. Yeah, no it's not a safe place, I don't find that a safe place, no. So yeah, any kind of group situation like that is not safe.

A binary gender construction does not allow for this participant's identity expression:

I wouldn't say I identify as an F to M, but I do identify as trans - as sort of a gender-queer in between categories, and as more masculine than feminine. I constantly get gendered as female because I appear female. I mean I am female, biologically speaking. Everyone just sort of assumes that's sort of the end of your - the beginning and the end of your identity and there's nothing else to it. (Shane)

In contrast to the above statements, some participants reflected that they refused to perform heteronormative silencing and invisibility. Kit offered the explanation that her level of *self-acceptance* did not allow for the enactment of this:

Why do I think I haven't ever been or felt silenced? I think it's just about *my* comfort level. It just doesn't allow for people to be uncomfortable with it.

Lexie states that she feels hyper-visible in certain contexts, and yet invisible in others:

I feel very visible and I've tried to make a point of being out and this is who I am, and I don't make any bones about it. But yeah, as a woman, especially in the non-gendered groups. I feel like I sort of stick out anyway. I mean I'm obviously a lesbian. I think I look gay ... I'm very identifiable.

Sher: You feel invisible as a woman?

Yes. And in the gender groups with being gay ... I feel invisible. Slightly repressed maybe. Just aware that this is maybe not socially acceptable necessarily to everybody. And that's a battle I may not feel like taking on the day.

My understanding here is that this participant feels invisible as a woman in co-ed drug use recovery groups, yet hyper-visible as a queer woman. At the same time she feels invisible or silenced as a queer subject in gendered groups. This example illustrates how an assumption of heterosexuality in the mixed groups manifests in a *marked* visibility (inappropriate, inaccurate, and stereotypically-dependent focus on gay/lesbian sexuality) of queer people (Daley, 2003). Because the participant has witnessed the institutional presence of homophobia and heterosexism, she remains silent regarding her identity as a queer woman: "That's a battle I may not feel like taking on." There is a voiced psychological stress imposed through *disciplinary normalizing practices* within the recovery group setting that manifests itself in these two seemingly different yet interconnected ways.

For some queer subjects, heteronormative discipline and regulation is accomplished through *internalized homophobia*:

I think if I'm not speaking my truth then for sure that makes me only half of who I am. If everyone else is saying: "I'm going out with my boyfriend this weekend," in a group setting and I'm saying nothing, that's only half of who I am. Like, if I'm not being excited about what's happening for me in relationship too, in a

relationship that I'm in, then it's definitely being silenced. And I think, I dunno, that's a weird one, because it's me that's silencing myself. (Danielle)

Here, Danielle illustrates why self-regulation through internalized homophobia is so problematic. She has internalized the view that societal assumptions of heterosexuality are essentially her problem. That is, she is doing to *herself*, and is to blame for any consequent discomfort. And what is the impact of this for her with regard to her problematic substance use?

There's that sort of idea I guess that it's not – whatever the abnormality of it is that you're not the daughter with the husband and kids and the picket fence or whatever – that whole idea probably kept me in the closet and drinking a lot longer than I ever needed to be. (Danielle)

Similarly, Lexie internalizes her embodied experience of normalized heterosexuality:

I had trouble when I was in treatment - when I was in my second treatment - because I was the only gay woman in the group. And my counsellors, I did tell them about it and they helped me. They said don't worry about it ... I found it difficult. At the time I was going through a break-up and I felt self-conscious talking about my feelings for another woman - my romantic feelings for another woman in a group of straight women. But you know it's my stuff, it's my feeling weird about it.

When participants spoke of what I interpret as internalized homophobia, there seemed to be several levels of discernment at work, or layers of negotiating disclosure regarding issues of sexual or gender identity. As one participant spoke of earlier, at times it is not a struggle that one has energy for on a particular day or in a particular setting. For people grappling with problematic drug use, the conflation of the issues in a heteronormative support setting is sometimes simply too much to engage in. As Danielle once again poignantly demonstrates, there *is* a price to pay.

I think [fear of] not being accepted by people ... Not sure how other people might view me, or what other people's reactions might be. If I'm not outing myself to people then I'm not giving them that opportunity. In the same regards, it's totally damaging to myself, because if I'm not outing myself I'm not being true to who I

am. It depends on what situation I'm in or how comfortable I am. But there's lots of situations in my day to day life that I won't out myself if I don't have to ... it's a work in progress, always. I would like to get to a place where I don't think twice about it, and then if someone has a reaction that's their problem. But it's still for me - I'll still choose to not say stuff in certain situations just based on my feeling around people.

Participants spoke to the tangible *work* of pushing through walls constructed by normative attitudes and a panoptic heterosexist gaze (England, 1999):

Honestly, every meeting that I'm at, if I do need to talk about it I feel there's a hesitation definitely before I start talking about, you know, my ex-girlfriend ... Part of me is a bit hesitant. I'm sort of gauging - my feelers are out for their reaction. (Lexie)

It's not overtly obvious. It's like, not necessarily wanting to make people uncomfortable, because you know people aren't comfortable with it. It's almost like bringing up a topic that nobody kind of gets right? Like bringing up an issue amongst people who - it's not an issue for them, so why bother bringing it up, because they have no experience and no desire to even talk about it. (Angie)

Angie illustrates how queer subjects carry out the labour of heterosexual hegemony through silence. Issues outside of a heteronormative purview are not really considered genuine issues, therefore manifest as non-existent.

Maria points out how the full benefit of proffered services seems contingent on assimilating into the heterosexist hegemony. She has internalized the perspective that it is in her best interest to remain in the closet, and demonstrates the power of "don't ask, don't tell" discourse. Once again, through self-regulatory practices, the queer subject carries out invisibility.

Sometimes I get the impression that people wanted to think I didn't have a sex life. You know, like that I was totally a non-sexual identity.

Sher: In the context of accessing supports for drug use issues?

In the context of accessing support services I felt it was in my best interests not to say anything at first [about her non-heterosexual identity]. Because being

accepted is such a huge part of taking those services and using them to your utmost. (Maria)

Maria demonstrates the challenge, for queer people, of achieving acceptance within the recovery community. In this instance, there seems to be a tension for her in negotiating community in multiple areas of marginalization: as a queer-identified person, and as someone wanting to belong to the community of people in recovery from problematic drug use. The tension occurs in seemingly having to reject one community for membership in the other.

Internalized homophobia manifested in fear for personal safety in some instances where a participant had sought gender-specific housing for problematic drug use. At times that threat to safety or sense of fear is on the level of (dis) comfort.

I was scared to talk about it. I was scared everybody would dislike me. Like because it is a house full of women I was scared they would start getting weird like: "I don't want you to use my toilet. I don't want to sleep in the same room as you." (Maria)

In other cases, or in particular settings, what may be understood as the regulatory effect of heteronormativity is experienced on the level of potential harm to physical well being. This next participant's analysis speaks for itself:

I think that most violence, especially violence coming from a stranger, is an example of an attempt to regulate, especially regulate deviations from gender norms. And I've definitely experienced that. I had a guy a while ago try to - I was walking through downtown at about three am coming home from the bar - and he tried to force me into his car because he wanted to touch my pussy to be sure that I actually had one. Which, you know, I definitely read that as a form of gender regulation and sexual regulation. I didn't fit into his category of what he thought a woman or a man should be. Other much less violent and much less shocking examples of that have just mostly happened, strangers approaching me or my friends trying to get to the bottom of what we are because we're read as being outside of acceptable categories. (Shane)

Similarly, Nicki speaks of disciplinary practices in both a literal and allegorical sense:

I haven't been disciplined as of yet. But I certainly feel that if I do continue, if I do allow my facial hair to grow then I'm going to be asked to leave. So now I feel like my home [recovery house] is being threatened. I feel like again I'm being shut down. Again I'm being told I can't be who I am, and left with no support, really, because there isn't any. But if I pursued the support that I'm going to need, I *do* feel like I'm going to be punished or asked to leave, you know. And I'm afraid to leave because I'm not ready to go out in the world. I don't have enough recovery time. It's a threat. I feel threatened.

This statement illustrates so clearly the Catch 22 of accessing status quo supports offered for drug use problems. One serious dilemma is a binary construction of gender that evidently excludes some people in gender-specific housing supports for problematic substance use. Nicki will potentially be disciplined for expressing a gender identity that is true to self and not manufactured according to normative practices: "I can't be who I am." The irony is that the *recovery* paradigm is based heavily on a discourse of self-acceptance, assertiveness, honesty, positive self-esteem and self-worth (Rapping, 1996). Matthews et al. (2005) describe the disjuncture in this way: "an often very real need for secrecy regarding sexual [identity] and the equally important need for honesty as part of a recovery program" (p. 57). In this next section, I further deconstruct data that refers to drug treatment settings (including 12-step), and other institutions, namely medical, psychiatric, academic, and social services.

### ***Heteronormativity in institutional settings***

Participants in my study availed themselves of many different supports both directly and indirectly related to drug use. The scope of institutional connections ranged from universities, health and social services, to formal supports for substance use problems: 12-step programs such as Narcotics Anonymous and Alcoholics Anonymous (a wide range of groups exist, including gendered and a few GLBT groups in certain

urban areas); a 16-step program<sup>10</sup>; individual therapy provided by private practitioners; group and individual therapy/counselling provided by health authorities; residential and day drug treatment programs, both private and subsidized; psychiatrists and physicians; and a transgender health clinic. Respondents gave examples of homophobia and heterosexism experienced in all of these settings. That is not to say that institutional supports were not essential and helpful to participants. Eight of nine respondents utilized formal supports for drug use problems, and all eight stated that benefit was obtained from at least one of these sources at one time or another.

Very rarely today, in institutional settings or social and health organizations, does one see outward displays of homophobia. The nature of institutional heterosexism more commonly takes the form of “don’t ask, don’t tell” – a potent discourse as mentioned earlier. However, the unstated disciplinary influences of heterosexual hegemony are unfortunately “loud enough to enforce silence” (Daley, 2003, p.105). By examining the workings of power relations concerning heteronormative practices through the theoretical literature discussed in Chapter 3, I have developed insight into *how* and *why* queer women may practice silence regarding their sexual identities. This may occur even when there are governmental and organizational policies that exist to safeguard against discrimination based on sexuality. In settings where the assumption of heterosexuality in society is not explicitly taken up or challenged, and subsequent drug use treatment modalities do *not* account for influences of heterosexism and homophobia, the data demonstrate that queer women sometimes do not feel included or see their lives reflected in proffered supports. As Danielle reflects:

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<sup>10</sup> Based on the work of Charlotte Kasl (1992), this is a 12-step modelled program that utilizes a feminist approach.

Oh yeah the wording! Jeez, oh my God! I'm just thinking of handouts that I got that would state - yeah, queer people are excluded ... I got lots in the day program and the other educational one, handouts about being in a relationship and it was always to the opposite sex ... my gut would just go into a knot or get a little stab in my gut and go: "That's not you, that's not you."

Sher: And how did you feel after that in terms of being able to participate?

Well it's that silenced feeling. Like I just probably wouldn't say anything, or I wouldn't contribute. I think maybe once I said: "Oh, maybe you guys should consider changing the wording in here." I think, too, you're in such a vulnerable place, trying to quit any addiction you are in such a vulnerable place, probably have so many millions of things going on, not always clear-headed. Uh, vulnerable, shame, despair, whatever, all these feelings are coming up. So I don't think anyone that's going through that is at their strongest. If anything you're at your absolute weakest. I don't think a lot of the time I had any fight in me to even comment on anything. At the strongest place in my life I still struggle with coming out in certain situations, so at the weakest - it wasn't something I had in me.

Danielle movingly relates that a susceptible and exposed participant should not need to contend with heterosexist drug treatment program content. In an article that examines a pilot study of an assessment tool used to determine sexual orientation, Barbara and Chaim (2004) discuss several problems with reaching queer clients who may otherwise not identify themselves. This may result in less than ideal treatment outcomes, as this next participant describes:

I did seek help in the past and I've been to treatment three times. But it was the old medical model - boom, boom, boom. Abstinence, total abstinence ... Thank goodness the treatments were there. But they weren't addressing the issues I had. I could have broken up with a partner at that time, which made it a more difficult time, and used and ended up in treatment. That's usually what happened. So addressing my needs in group? I didn't feel like I could come out. (Isabel)

Lexie offers an analysis of the problem, made manifest in textually mediated heterosexism:

I was just reading one of my papers the other night. I can't remember - it was about relationships or something. I was reading along and it was really good and then I flip over and it says: "This will help you relate to the opposite sex." And I

thought, god you know, they've gone so far. There's no reason why this couldn't be completely de-oriented or whatever.

Sher: Made inclusive?

Made inclusive. You know they've managed to take all the he/she - you don't see he slash she anymore. They've made *that* kind of language gender neutral. Like why can't they make it sexual orientation neutral? Maybe it would just be a matter of them finding the money to go through all of their forms and do that. But I don't think it's that. I think it's just this: They just aren't aware of it. (Lexie)

As evidenced by responses of participants, the assumption of heterosexuality is completely embedded within the textual offerings of the drug treatment setting. What may on paper seem simply a matter of semantics can, and unfortunately does, distance a queer-identified subject far enough from the support to render it ineffective.

Participants described heterosexual hegemony as manifesting in myriad forms. Maria relates her experience of one form of inequity manifesting through regulations in a mainstream treatment setting. The situation appears to be justified by what has been referred to as “reverse discrimination” (Frye, 1983). As Marilyn Frye points out in her essay on oppression, there is really no such thing as reverse oppression/discrimination. For example, individuals and groups may feel that they experience certain limitations or instances of suffering, yet it does not mean that they are oppressed as a *people* or an *identity*.

I wasn't allowed to go to gay meetings, and I didn't understand why that was. I mean, in one of the recovery houses I wasn't allowed to go to the gay meetings because it excluded everybody else. See, it's not a tit for tat sort of thing, right.

Sher: So, let me get this straight. You weren't allowed to go to gay meetings?

Because it would make others feel uncomfortable and they would feel left out.  
(Maria)

Maria identifies as a gay woman yet is told that she is not able to attend GLBT meetings

because they are understood to exclude straight people, thus making them feel “left out”.

This next quote illustrates how Nicki, who is involved with a similar institutional housing support, feels - and is - excluded because of an identity that transgresses gender norms.

The one-size-fits-all heteronormative paradigm does anything but fit in this instance:

At treatment and the recovery house that I'm in they had spa night, makeup night, and, you know, I was dreading it. I was just dreading it. I'm thinking, how am I going to get out of this, they are going to make me go because it's part of their recovery program thing, and people were teasing and saying you know, they're going to use me and dress me up and put me in makeup and all this stuff, and I find it, you know, very shameful for me, very embarrassing. And so I just refused to go, which is fine I guess, except that they sent me to a movie all alone by myself, which also made me feel separated and different. Do you know what I mean? I was damned if I did and damned if I didn't. I feel excluded, not a part of.

Thus, an intended (one-size-fits-all) support acts as a barrier to inclusion for this participant, though for some trans-identified persons a “spa night” might be appealing. It may be of note that some *male-to-female* transgendered persons would likely not be able to stay in the referred-to drug recovery house, which may only be accessible to biological females. The subject of support and barriers to support will be explored in more depth later in this document.

Kit was the only participant who, throughout the interview, reiterated that she had not experienced the effects of homophobia/heterosexism, or rather that these oppressions did not impact her life in a negative way. However, when I asked if she could recall a specific incident (see Appendix A, question 8 prompts), her response indicates homophobia stemming from individuals within the 12-step community and other mainstream self-help groups:

I just thought of an instance where I was shut down. It was when I had about four months clean, about a year and a half ago, and I was asked to speak on a panel. Part of what you do on a panel is you tell your story. Well my story is that I have a female partner. My story is that I'm a lesbian; that's my identity, that's who I am.

So anyway, I can't remember in what context I was talking about it when I was telling my story, but it fit into what I was talking about anyways, as part of *my* story. So the next day, I got a call from the guy who had been chairing the group. And apparently one of the people on the panel had called the chair of the NA panels to tell him that they need to screen the people they have on panels better. There was a lesbian who continually talked about her female lover and he didn't think that was a good message for us to be putting out there ... So there's certainly some homophobia that goes on in NA for sure; I don't experience very often. That's the one and only time that I've experienced it.

Angie verbalized a sense that the 12-step community in her experience was generally not responsive to issues that would engender a feeling of inclusion for non-heterosexual members, or an acknowledgement of their distinct issues.

I don't feel supported by people where I can go and bring up these issues and not feel like alone and attacked by various people so-called in power that are not even supposed to be in power but you know, there are so many control freaks in Narcotics Anonymous it's not even funny. But I do, I do feel silenced and I do feel not heard, and I do feel like the status quo is running the show. (Angie)

Narcotics Anonymous and Alcoholics Anonymous self-help groups were the most frequently cited supports accessed by my study participants. Seven respondents had at some point attended co-ed, gendered and/or GLBT AA and/or NA. As mentioned earlier, the majority of the respondents in this research study availed themselves of mainstream supports offered for problematic drug use, despite the heteronormative bias that was recognized by all participants regarding at least one support that was utilized. This is significant because AA and NA groups are free, participant-run services, available in every small town and city in Canada (and elsewhere). 12-step group popularity is partially augmented by long wait lists and lack of other public treatment services for people experiencing problematic substance use. Furthermore, court ordered treatment often requires attendance at NA or AA (Boyd, 2004). Based on a desired goal of sustained abstinence, 12-step programs are a modality developed by and for addicts and

can be accessed in a flexible fashion regulated by the individual (Acker, 2002).

Lexie spoke of the silencing and distancing impact of perceived or potential heterosexism, which impacts her level of participation in mixed gender drug support groups (offered by provincial health authorities), and to a certain extent in gendered groups as well.

Especially in the mix gendered groups. Buddy from [place name] with the ball cap – I don't know if his reaction is he's going to laugh when he hears that I'm a lesbian ... Or is it going to be the sexual voyeuristic thing to talk about my relationship with another woman. It's a bit nerve wracking. And it's still a bit in the women's groups just because most of the women are straight. And I don't really want to be a source of entertainment. (Lexie)

Angie sums up her journey toward recognizing the importance of foregrounding queer issues for queer persons impacted by problematic drug use:

The recovery community ... - people who aren't queer or who are basically heterosexual - the majority of the people do not understand queer issues, don't care, and it's a non-issue sort of thing. But it should be right? Like, this is something that I've *learned* [referring to the importance of queer issues], I've become *aware*, and I've become aware of things that are meaningful.

This next participant's words describe the experience of exclusion due to transgression of gender norms. Additionally, Nicki introduces the notion that certain issues faced by queer persons are *different* than issues faced by exclusively heterosexual persons. The results of one relatively recent study lends empirical support (Matthews, Lorah & Fenton, 2006) that is consistent with the findings of my research study, indicating that distinct challenges confront the subject population in recovery from problematic substance use (Cheng, 2003).

You go to these support groups and you're the only person there who is lesbian. Even in treatment again, you know, the only lesbian there, right. I didn't feel comfortable. People started calling me brother, and started treating me like I was a guy, and you know I don't feel comfortable being in a group that I'm the only

gay person there. For one thing because I think there are different issues. I don't feel a part *of* somehow ... I'm separated from the pack. (Nicki)

In Chapter 3 I discussed the historical treatment of non-heterosexually identified subjects by the *psychiatric system*. In what seems to be a hangover from this deplorable period, several participants conveyed that they had been referred to psychiatrists or psychiatric institutions because of what sounded like a conflation of substance use and sexual identity issues. These subject positions were perceived by the psychiatric system as marked areas of deviancy and psychopathology (Acker, 2002); occupying both would see a person viewed as *doubly deviant*. None of the participants reported satisfaction with results, and felt that the referrals had been misdirected in the first place when not for specific issues related to mental health concerns/diagnoses (i.e. major depression). One participant recalled a referral that sums up the notion of “misdirected”:

Well come to think of it when I was younger [participant appeared to be in her 40's] – when I was 19 – they didn't know what was wrong with me: “Well she's just an alcoholic” [Laughs]. But then I started opening up to a psychiatrist about being gay and having all these feelings. So that's when they wanted to put me on Chlorpromazine.<sup>11</sup> I wasn't seeing things so I don't know why I needed that. Chlorpromazine started to make me shake after a while and then I needed something else to stop that. In a way that's a regulated kind of “put her there in that box”. (Isabel)

Isabel summarizes with a sentiment that arose persistently throughout the interviews.

Participants spoke as though their identities and distinct issues did not really matter, especially to others not likewise impacted because of minority status:

I'm one one-hundredth of a minority in terms of who is seeking service. That's where I feel myself that I'm invisible. And part of that, a big part, is probably just me feeling that but I pick up on peoples' energies and then I think is it safe to open up or not.

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<sup>11</sup> Chlorpromazine is the oldest typical antipsychotic used to treat: schizophrenia; mania in people diagnosed with bipolar disorder; and for severe hiccups. The shaking described by the participant is a potential known side effect of this drug (Gorman, 1997, p. 227).

Once again, the queer subject enacts invisibility due to heteronormative influences, and this mediates if and how services are sought for problematic substance use.

### ***Importance of openness regarding sexual identity***

There is one question that does not appear in the interview guide, though it either was asked in various phrasings or inferred within the responses of participants: I asked if acknowledgement of identity and attention to issues distinct to sexual identity, were even *important* for participants in the context of receiving support for problematic drug use.

Every respondent had something interesting to say about this subject, but these three quotes describe the essence of identity recognition most distinctly:

Sher: How essential is it for you to go through your experience as a *queer* woman in your recovery process?

You mean if I felt silenced and still had to try and do recovery? [Pause] Yeah, that would be hard. I'm just trying to imagine it, because it's just not my experience. I couldn't imagine denying that part of me. I wouldn't, because: a) you need to get honesty to get recovery, and if you can't be honest, you're losing half your program, three quarters of your recovery. And b) if you can't get honest, you can't stay clean. I've had to get honest about a lot of stuff, but I had to make myself feel safe doing it. (Kit)

Especially I think in dealing with overcoming addiction ... maybe queer people struggle with it more. Because for me, personally, having so many feelings of shame, or not belonging, or not fitting in, or not being worthwhile - all of this stuff - and drinking and drinking and drinking, and then all of a sudden quitting drinking and no longer drinking. You have five thousand hundred emotions coming up and it's a horrible time. And you're so crazy trying to deal with all these feelings that you maybe have been stuffing for however many years. And now all this stuff's coming up and to not be able to talk about sexuality as part of that. It's like you only heal so much because you can talk about everything else around here but if your sexuality is core to who you are, if you can't freely discuss that ... Does that make sense? (Danielle)

To get to the issues that are driving you out there to keep on self-medicating yourself, then if you can't be who you are, you are just going to go through the motions, jump through the hoops while you're there, and squeeze on by and come out of there like I did, with not dealing with anything. (Nicki)

These and other comparable responses from participants in my study indicate that recognition of issues relating to sexual identity is vital to helping services for problematic substance use. In a qualitative study of gays and lesbians in recovery from addiction, Matthews, Lorah and Fenton (2006) examined past treatment experiences of participants via semi-structured telephone interviews. One of the primary themes identified in the study was identifying factors contributing or hindering participants' ability to be open about their sexuality in the treatment setting. Satisfaction with the support services was directly correlated with the ability to be open about sexual identity and related issues. Similarly, the participants in my study elucidate how important disclosure of sexual identity is to recovery.

Isabel illustrates how heterosexist discourse in drug treatment settings implies that everyone should be treated equally and therefore the same.

I think it's in the treatment curriculum that's laid out there for people who go to residential treatment centers. It's an all-in-one package deal. And so that's where I felt silenced, where I couldn't open up about my own experiences with my ex-partner or the issues I have about coming out with my family, friends, things like that. So in that sense – whether it was in residential treatment or aftercare – I still felt like there was a big piece of me that I couldn't talk about. (Isabel)

Thus, according to heteronormative curriculum, equal means heterosexual and queer peoples are rendered silent and invisible. Other participants described indirect ways that a non-heterosexist atmosphere is so vital to receiving adequate support for substance use problems.

I think we're totally excluded. I think that's a part of what makes me want to go in the closet every three or four years is because I just want to be accepted for who I am. I don't want to be the unique little dyke in the group, you know. Like I just want to be accepted for me. (Maria)

I certainly recognize the need for a lot of improvement and I see a lot of heterosexism in NA. ... Recovering addicts in Narcotics Anonymous, in the fellowship, just don't challenge anything when it comes to that. We don't want to talk about the things in life - heterosexism for instance - it's not a topic. And even if I've said that word - and I've said it every once in a while - it just zoom right over people's heads. Absolutely no fucking idea what I'm talking about. I've brought it up once in a while because sometimes I just explode. (Angie)

It's happened multiple times with multiple different doctors. Any time you go in for STD testing and stuff like that, hearing, first of all, never having the question asked what type of sexuality *are* you, and instead getting lectures about - I've gotten lectures about I don't practice safe sex, and lectures about condom use, and I've been like well actually - You know there's just that assumption. So you sort of end up having to "out" yourself to your doctor and then getting these "Oh!" sort of responses initially when they don't just sort of smoothly take it in stride. There's this whole like process of having to come out to your doctor. (Shane)

In a study that examined addiction counsellors' attitudes and behaviours toward lesbian, gay and bisexual clients (Matthews, Selvidge & Fisher, 2005), results indicated that a non-heterosexist organizational climate was one of three factors that determined an affirming attitude toward the subject population. The more affirmative the organizational climate, the more counsellors reported affirmative attitudes and behaviours in working with this population. Reinforced by my research, my view is that a non-heterosexist organizational climate would best be achieved by policy that clearly indicates both an intolerance of discrimination against, and an awareness of, queer-identified clientele.

The participants in my study affirm that spaces encouraging openness, including openness regarding sexual identity, are a core feature of helping services for problematic substance use. Formal drug treatment programs, and professional medical/social services, would be enhanced by education concerning diversity of identities, and implementation of policy/program/service features that reflect the non-exclusively heteronormative make up of our society. Self-help groups, constituting a cross-section of society and leaderless in nature, are subject to heteronormative mores and thus are a complex area to propose

transformation. Research participants have, nonetheless, suggested many ways that they position themselves within these groups to effect change, both individually and systemically.

## **RESISTANCE**

***There are some times when I really just gotta put my foot down and just say: No, that's not right. Like, you need to be inclusive. You need to stop seeing me for who I go to bed with and see me as another person in need of help. (Maria)***

In the analysis of the major theme of *resistance*, the data are categorized into four subthemes: resistance as it was explicitly defined by the participants; resistance recognized through my interpretation as the researcher; and contested resistance, or positive aspects of drug use. I have also included a fourth sub-category due to its connection to the central concept both historically and contemporarily: *two-spirit* identity and resistance. On first blush, there emerged a dearth of self-described acts of resistance by respondents. However, during further examination of the data while utilizing the theoretical lenses explored in the previous chapter, a wealth of responses indicated what I came to understand as acts of resistance to oppression. For interpretive assistance, I turned, in part, to the works of Allan Wade (1997), Paula Gunn Allen (1998), bell hooks (1990), and Iris Marion Young (1990) in the process of identifying what I took to mean as expressions of resistance by participants.

### ***Participant defined resistance***

All participants were asked at some point during the interview how they “resisted” oppression. For the purposes of this research study, resistance is understood to mean how individuals respond in a manner that enables them to survive - and in some cases thrive - within homophobic and heteronormative communities and institutions. Six of nine respondents expressed what I interpreted as *consciously defined* ways that they resisted oppression related to their queer identity and/or problematic substance use. When the question was posed: “Can you talk a little bit about how you resist?” Shane replied:

My own very personal form of resistance is writing. I'm a writer, and I write to try to get published, which, you know, happens from time to time. And just trying to put a voice out there and share experiences ... I guess that's a small form of resistance.

Other respondents spoke to particular behaviours and transgression of gender norms when referring to self-described resistance.

I let my facial hair grow, and it's something that's a part of me; it's always been that way since my early twenties. It's not testosterone-induced, it's just who I am. And so I checked it out with the women in the house [referring to an addictions recovery house] and said I was just going to let it grow ... checking out my comfort zone, checking out the world out there, people's comfort zone. Everybody in the house said they were fine with it, and apparently someone in the house wasn't fine with it, went behind my back and, you know, started spreading these rumours and stuff that I'm transitioning in the house ... But I did resist ... I put myself *first* in that situation. (Nicki)

I like keeping my hair short and cropped and I dress in men's clothing for the most part. I try not to hide my orientation. I try not to anyway. (Lexie)

A two-spirit participant related resistance to an intrapersonal process, and describes it in the language of the therapeutic:

Part of my resistance is to build up my self-esteem and perhaps do more self-care. If I am stronger in how I feel about myself and not shame-based all the time, I'm better able to be assertive and know what my rights are and act upon that. But you have to go through a whole lot in order to come out that way [Laughter]. Which is good you know. (Isabel)

Resistance took the form of advocacy within the 12-step community for this next respondent:

I've learned over time how to work within the system, and like, if I don't like how a particular meeting is, I'll start one. And one of the things that I've actually learned is that because I can't change people, I can facilitate their change by providing space and literature and a safe place to work on their recovery and talk. (Angie)

In contrast to the above-stated responses, resistance may also be expressed through an *absence* of action. Allan Wade's therapeutic methods focus on exploring

diverse ways that individuals may respond to oppression and violence inflicted upon them. He purports that it is necessary to take into account the political and social atmosphere in which the oppression takes place. Rather than view the myriad responses as pathological or maladaptive coping mechanisms, “victims” may discover how their responses are acts of resistance, and encompass incredible courage and power within the context of responding to abusive situations (1997). Framed in Wade’s view, a reaction of withdrawal or silence may indeed be an act of resistance that carries with it an empowered response to oppression. Nicki relates:

I just keep to myself as much as I can I keep to myself. I don’t get involved ... I mean I sort of look more like a guy than a girl I guess, and the way I walk, the way I dress, is a form of protecting myself, you know. Um, yeah I dunno, I just isolate.

The shadow side of this form of resistance to societal oppression is that isolation may act as an impediment to receiving supports for problematic substance use. The subject of barriers to receiving support will be further elaborated on in discussion of the *support* theme below.

### ***Researcher interpreted resistance***

All nine of the research participants offered responses that I was able to interpret and include within the rubric of resistance, even though they did not directly identify their responses as such. Many responses directly related to some form of publically overt reference to the participants’ sexual identity. That is, the participant expressed an “out” standpoint regarding their queer identity. bell hooks (1990) suggests considering social marginalization from a differing perspective other than a place that one is assigned in relation to a heteronormative centre point: “For me this space of radical openness is a margin – a profound edge.” (p.149). By choosing and utilizing the margin as a location of

resistance, the “victimized” may claim the space of “difference” and “other” as a site of action rather than a place of persecution. It is here that resistance finds a home. Viewing the margin as a site of resistance and “choice” (to appropriate liberal language) is thus a more fertile and potent panorama. Iris Young (1990) distinguishes a “politics of difference” as a site where marginalized persons may create distinctive self-definition and recognition of culture that is celebrated, not despised. In their own words, participants describe how their identities and truths are claimed:

It’s never occurred to me to not sit and tell the truth. So I think that that is why I just go wherever I need to go to get the help I need, and being a gay woman is not an issue for me. (Kit)

I *try* not to hesitate to have physical, public displays of ... PDA's - public displays of affection - with whoever I'm dating. When I first started to it was nerve wracking. It was very difficult. But now I feel much more comfortable with it. (Lexie)

I'll like fight for what I know I need. I'll fight for it. And I don't have any problem speaking my mind, being clear about it, using the resources that I can find. (Kit)

There’s a little bit of a hesitation there in that moment of disclosure, and I think that's why I'm really up front, like right away: "I'm gay!" Maybe they'll be a bit forewarned of what will come out of my mouth ... (Lexie)

Angie expresses willingness to self-locate within areas she identifies as socially privileged. This transgender activist beautifully articulates both the challenge and potential reward of embracing a non-heteronormative identity and a lifestyle free of drug use:

It’s easy for me to revel in my whiteness and my middle-classness, right? But it’s another thing to challenge things and to get involved. So I can just see a lot of people just don’t do that ‘cause somehow they think, “Oh I'm powerless”, or whatever. I kind of really am a bit mystified by why people get clean or get sober and just like work really hard at being so-called normal people again, instead of revelling in their uniqueness and their individuality and understanding that yet they are all connected to everything. (Angie)

At times during the interview process expressions of resistance emerged when participants were asked the question: “Have you ever felt silenced?” Respondents described how they challenged heteronormative silencing, sometimes overtly.

No, because I usually put it on the table. Say, for instance, in detox with like all these fucking hard-core street junkies and we're all sitting out in the smoke pit and somebody says something that I find offensive. I'll be like: “Watch your mouth, I'm a fucking dyke”. And that pretty much breaks the ice. (Kit)

As a gay woman, when I walk into a recovery club I know that everybody there is straight. Maybe like one or two women or men are ... [gay] And I hear the little comments that fly by and I don't appreciate them. And I usually set someone straight. (Maria)

I also asked respondents: “Were you able to be open about your sexual identity when accessing supports for substance use issues?” Similar responses were given when I asked both questions, though one referred to silencing and the other openness. One person noted their success with using a direct approach, and I interpreted this as an act of resistance on the part of that individual.

Completely. Mind you I am open, so ... to hell with them [laughs]. So I didn't feel any kind of limitation. (Lexie)

This next participant expressed resistance in the desire for a better future for her child. By sending a clear and consistent message to her daughter that she is acceptable just as the individual she is, Jamie offers a counter-hegemonic perspective regarding sexual orientation, gender identity, and drug use. Jamie's perspective highlights that the “norms” produced by the dominant culture are not neutral and universal (Young, 1990). I interpreted this vision as resistance.

I tell her that when she's old enough she will make her choices - who she's dating - male or female. It's her choice to make, not mine. I'd have no expectations on whether she's heterosexual or not. And when she chooses to try experiment drinking and drugging she'll make her choices. It's not my choice to make. So I'm allowing her to be that little individual. And there's the difference in parenting ...

So if she meets other same sex couples - mostly lesbians - it's okay. And uh yeah, I think it's a huge difference for her. And that's where a lot of my motivation comes from, in what can I do to make it a better life for my child? Continuing to break the cycle, whether it's drugs and alcohol. Putting a voice to it's okay to be gay; it's okay to be two-spirited. (Jamie)

I was surprised at how recurrently laughter erupted during the interview process, despite the serious and often sad tone of discussion related to the subject matter. This happened with each one of the participants with varying frequency. Humour as an act of resistance may be an understudied area of research, yet it has a potent history in non-violent resistance to oppression by marginalized peoples (Sorenson, 2008). This next participant often used humour as a form of resistance:

There's a lot of people are scared of gay people. You know, like I don't understand it, and I usually try and break up the uncomfortableness with laughter. (Maria)

Resistance took the form of educational advocacy for two-spirit participants, in relation to addictions treatment and other forms of service *and* First Nations identity:

What we've done, because I was sick and tired of not getting the real help, not even just for me but for others, for gay and lesbian – is to bring in terms of traditional Aboriginal ways and beliefs. We took a series of twenty doctors into the sweat lodge so they would understand how that is and how that feels, and to have the cultural sensitivity to anyone coming in your office and talking to you if they're from a different culture. (Isabel)

The above quote demonstrates how resistance to colonization continues with First Nations people challenging assumptions. The participant went on to describe including other medical personnel and subsequently RCMP in this method of education through experiential cultural practices. Another First Nations participant has a goal for the future:

My long-term goal is to work in addictions, particularly with youth, especially those who identify as two-spirited or questioning. It's just ... there was times when I felt so alone that I didn't know who to tell. I wanted to but it was the fear of the reaction. You know, would I be disowned by my family? Uh, how is my daughter going to handle it ...? So, as far as accessing support, I'm kind of on the

other end where I want to create the supports. (Jamie)

Near the beginning of each interview, participants were queried as to why they wanted to get involved with the research study. Though this question was asked as an “icebreaker”, it elicited responses from several participants that I interpreted as expressions of resistance. Another way to understand this response is that involvement in the research is a form of giving back to others engaged in a similar challenge. The struggle is for acknowledgement and response to distinct issues related to sexual identity in the drug use support milieu specifically, and health care services in general.

I thought I'd help you with this research because there are some gaps in the knowledge base that the medical profession has in terms of who we are and what our needs are. And as a two-spirit person I've faced those barriers too. Although not always overtly but I still face them. So it's like barriers to seeking help right. If you don't get treated well you're not going to go back. (Isabel)

What prompted me to participate was what you named it ... the heteronormativity clause statement, and I was like, I don't see that very often. It's a word that is very seldom used. We dust it off the shelf once in awhile. That really caught my eye. And I just thought that like recovery houses, treatment centres, [health authorities] of course have changed a bit. But even just like a lot of our health care system is really heterosexist in a really big way ... I felt a need to see if I could do my bit to help out, because I understand the need for inclusivity within all areas of Canadian society. (Angie)

I'm not an activist, but I do think if you can do something to help people get better services you should try and get involved. (Maria)

I think it's this kind of work that's being done in addictions that has just got to be supported. It's so essential. I think the whole approach that's been taken by government is fucked up, you know, in a lot of ways. They aren't looking at the people that are addicted and what their issues are, as opposed to, you know, enforcement and all those kinds of crap. So I'm really happy to add to the knowledge base. (Lexie)

I just think that there are a lot of issues with substance abuse in the queer community that aren't necessarily addressed. It's not really addressed like how substance abuse affects queer people specifically. And I thought that's probably a good thing that someone's doing research on those kinds of issues. (Shane)

As has been demonstrated by the voices of participants, those in need of services are also interested in an *exchange* of giving to others, where information is shared, gaps in research are filled, and heteronormative silencing is resisted, all toward a common goal of change at both personal and systemic levels.

Nicki speaks to the sometimes silencing effect that stems from heteronormativity in society, and how it may be activated through various support systems. Nicki also regards involvement in the research process as a contribution, and perhaps as an outlet for an otherwise silenced identity in the context of accessing particular supports.

Well, [laughs] I wasn't sure what I could contribute. But, you know, something told me that I need to be here. I'm going through it right now at the [recovery] house, having to shut down and just maintain, you know. Get through each obstacle or whatever to stay there, don't push the envelope, don't be who I am. Uh, this [participation in the research study] is, you know, a contribution of sorts. (Nicki)

The rights that are “granted” by the dominant culture - in this case, access to an addictions recovery house for women - are more of a reward for assimilating and “passing” within straight society: “Don't be who I am”, says the respondent, indicating that a level of conformity to gender norms is required for relatively easy access to this safe/supported housing. The tenuous tolerance of queer identities is contextually limited to those that assimilate well into the mainstream. This participant decided not to “push the envelope” in order to access services and assuage discomfort with being identified as the “other”. Urvashi Vaid (1995) describes this as the mainstreaming of queer peoples. “Assimilation was an option for those who were willing to mute their queerness: to not tell or to pass. For those on the queer margin, like effeminate gay men or butch lesbians, sexual heretics, and gender rebels, the new center still offered an uncomfortable and

unsafe refuge.” (p.182). With regard to accessing (or not) support services, it seems that heteronormative behaviours, expectations and appearances define the margin itself.

***Positive aspects of substance use: Contested resistance?***

Another “icebreaker” question asked near the beginning of each interview queried participants’ relationship to drugs, including alcohol, prescription, legal, and illegal drugs. As respondents delved into their substance use histories, stories emerged that contained seeds of resistance that I came to classify as *positive aspects of drug use*. The use of the term *positive* - used in the sense of being affirmative, helpful or enjoyable - may be highly contested, as it could be argued that the use of drugs was, or came to be, a maladaptive tool/behaviour for all participants. However, many drug researchers illuminate how psychoactive substance use is not in essence “damaging”, and is expressed in various ways in different cultural and social settings (Boyd, 1999; Boyd, 2008; Coomber & South, 2004; Duff, 2008; Valentine & Fraser, 2008).

Eight of nine respondents described one or more of the following: substance use facilitating a “coming out” process in some instances; drug use as a societal “norm” for the queer communities as a way of “belonging”; drug use easing the process of connection with others; the bar scene as one of the only meeting places for queer peoples; and substance use as a coping mechanism (for example, coping with the phenomenon of internalized homophobia). Harkening back to my original characterization of resistance at the beginning of this section, many participant responses fit this definition: how individuals respond in a manner that enables them to survive - and in some cases thrive - within homophobic and heteronormative communities and institutions.

The use of some form of psychoactive substance(s) is a norm within most societies (Weil & Rosen, 1993, as cited in Boyd, 2001), and conceivably always has been in cultures throughout the history of humankind. Research suggests that this phenomenon may be even more prevalent in queer communities in general (Hughes & Eliason, 2002), and amongst sexual minority women specifically (Corliss et al., 2006; Rosario, 2008).

Several participants in my study related how drug use was correlated with their experience of finding and forging community.

It was definitely through the queer community that I started using it [drug of choice]. People introduced me to it and stuff like that. (Shane)

All gay, all queer people - I don't even remember having any straight friends at that point. I'd completely just become one of the crowd. And there was a group of about ten of us that all hung out together, and we all used needles. Um, we all partied at the same place, men and women. That was just the norm. Then life became about getting high, that's what it was. We still went to the bar, managed to drag ourselves to the bars because that's where everyone else was. (Kit)

I started using more drugs when I started into the gay scene ... gay society at that time [1980's] seemed completely surrounded by drugs. You know, it was a part of the culture. You didn't go out and dance without getting high, and dancing is such a huge bit of gay culture. (Maria)

Drug use was described as a means of developing connection with others in the queer communities. For some it presented as a vehicle for overcoming feeling of internalized shame and stigma. For others it enabled social bonding.

I guess a sense of feeling connected to [queer] people ... it took away any feelings of shame, or feelings of not feeling worthwhile. And definitely there was a group of people that I hung around and drank with. So it was very much a connection amongst a group of friends. (Danielle)

I was able to *engage*. My first girlfriend was a user. We engaged ... you know, we would smoke and talk and really connect. I think it was really helpful for me in terms of being able to really say what was going on in me, and get used to talking about my feelings openly. I mean now I can do it without it. But at the time it was sort of needed - I needed to uncork. And I might have been able to do it some other way, but that's what worked for me at the time (Lexie)

I was having fun. Fun like I had never had. It was just amazing. I just felt comfortable - at home. If I got too drunk, people looked after me. (Kit)

The bar scene is currently - and even more so historically - noted as a meeting place for queer peoples. The lesbian bar has long been renowned as a cornerstone of lesbian culture (Gruskin, Byrne, Kools, & Altschuler, 2006) where women find and build community. Paula Gunn Allen (1998) views community as a key to resistance of oppressive power structures in society. In fostering community, she reminds us that First Nations' peoples, for example, have resisted extinction despite the efforts of colonizers and the insidious violence that has characterized this oppression. Allen views the fostering of collective nurturance as a way to solve many social issues including lack of familial support and a preservation of individual identity and uniqueness. She illustrates how community has a huge role to play in the resistance of oppressed peoples. Queer peoples often have no potential support structure built into their family and larger community. They are not bequeathed an inherent community, but must find it, build it, and foster it. Indeed, community *becomes* the site of struggle and resistance (Bobiwash, 2001). Respondents describe discovering community in the bar scene:

I came out in the community, and because of the bar scene and where to meet people, there was nothing really available to, you know, hook up with other [queer] people. I grew up in the bar ... (Nicki)

That's how you met everyone: in the bar ... Basically the 80's, I mean my story is that, through the 80's - and I still don't regret them - the only place for gay people to go to was the bars, you know, especially gay women. There was just nothing else to do ... That's where every friend I still have today I met in '81 or '82. Yeah, that's what we did so with that came lots of drinking for sure. (Kit)

You can't find women just on the street or through your friends; you have to go to clubs. (Maria)

One respondent clearly describes the possible challenge of visiting venues that promote the use of alcohol and other drugs as one of the only spaces to access community:

I had been at a women's dance recently and felt myself a bit triggered because there was another woman there who was using. And she was in recovery but she was off the wagon obviously and she was with her girlfriend and they were having a really lovely time. And I felt triggered ... My counsellor suggested that maybe I should consider not going to women's dances for a while, which is really standard counselling advice. But it's the only community that there is! It's more than the alcohol and the drugs ... it's the *community*.

Sher: You felt she didn't get it?

She didn't and she wouldn't. If she was a lesbian in the community and going to dances she would understand that they're more than - they're not just a party. (Lexie)

For some individuals, a lack of drug-free events and meeting places may act as a barrier to having their social needs met. When abstinence from substance use is the goal – as was the case with Lexie – attending gatherings where substance use is visible/celebrated may prove challenging. This participant has raised a complex issue because the bar scene and drinking/using events are both historically – and currently – vital points of connection for sexual minorities.

Five participants described drug use as a coping mechanism. Queer peoples may experience many forms of oppression relating to their sexual minority identity. In the data, respondents describe several ways that substance use “assisted” their journey of identity formation, or helped them survive societal homophobia, internalized homophobia, and frequently subsequent self-rejection.

I discovered alcohol took my fear away. And I was an extremely shy person ... I discovered I felt safe, and I felt like I could be *a part of*. ... That's how it started. It was just a medication. That's what I've been saying my whole life, that I've self medicated my anxiety, you know, my not fitting in to society, you know, so it started off like that ... (Nicki)

After the ostracization [for coming out] and from our culture there [First Nation], I fell off the wagon so to speak. That time when I was cast away from the society - this medicine society - I started to use again because I just felt like my faith was shaken from under my feet and my whole world was rocked about. And so the best way of coping that I knew was to self medicate. (Isabel)

I think drinking as a teen was an easy escape from ... small town homophobia. Not a safe place or a nice place to be realizing that you're gay in. And I think alcohol was just like an easy escape from that ... sort of creating that emotional distance from my own problems. (Shane)

Around the time I came out, a lot of my need to bury feelings and suppress stuff, and loneliness and all of those feelings ... it's like being in a room full of people and being completely alone because I wasn't out. And alcohol really filled that niche. And when I came out, alcohol dissipated. ... I really think coming out alcohol fell off dramatically; I just had way less to manage emotionally. (Lexie)

I have experience with addiction, a lot of years being in my active addiction really kept me away from a lot of that [refers to not being active as an activist], kept me from being in my truth so to speak. And I see that a lot in our society, you know, addictions, addictions, addictions right, how we just sort of, that's our sort of default coping mechanism for a hostile society that wants to control us. (Angie)

Research examining the relationship between heterosexist events, internalized homophobia and substance use found that lesbian, gay and bisexual individuals use drugs as a method of coping with so-called *minority stress* (Weber, 2008). Several participants have demonstrated how their experiences of negotiating the stresses related to homophobia and heterosexism influenced, and were influenced by, their use of drugs. As was mentioned above, although the participants in this study struggled with problematic substance use, they also used substances as resistance to oppression. Their use has been described in various ways as a tool to cope with the impact of heteronormativity in both everyday life and on a path of non-heterosexual identity formation.

### ***Learning from the past: Two-Spirit identity and resistance***

Two of the nine respondents spoke at length about their two-spirit identity, and how homophobia within First Nations cultures may be linked to European colonization of

their peoples. Indeed, identification as two-spirit within such a climate may *itself* be viewed as an act of resistance. These participants also clearly linked race and sexual identity as a location of interlocking oppression inextricably connected with their experiences of problematic drug use.

Two-spirit peoples are currently challenged to help themselves within their own communities due to the legacy of homophobia brought through the colonization process.

Native American scholar Paula Gunn Allen (1992) summarizes:

Recent scholarly work reveals the universal or nearly universal presence of homosexuality and lesbianism among tribal peoples, the special respect and honour often accorded gay men and women, and the alteration in that status as a result of colonization of the continent by Anglo-Europeans (p.198).

In spite of a present day atmosphere of oppression, two-spirit identified research participants were able to refer to a *tradition* of support within their cultural history. In contrast, the Eurocentric foundation of contemporary society does not offer such a legacy for queer-identified persons. Thus, in concluding this theme, I believe it is valuable to examine what may be learned from two-spirit resistance. In doing so I draw from responses of two-spirit participants in my study and writings of contemporary First Nations scholars articulating their thoughts on the subject of an extensive, and often beautifully complex, account of two-spirit people woven through their histories.

In order to comprehend the current situation of two-spirit people, it is essential to critically view the history of colonization of First Nations peoples. The pan-generational effects of the residential school system are vital to an understanding of the present day climate for two-spirit individuals, both within First Nations communities and the larger heterosexual hegemony. The broken bonds between parents and children caused immeasurable damage, the effects of which are very much a current issue in First Nations

communities. Patricia Monture-Angus (2001) points out that violence in First Nations communities today, an example of which is homophobia, is a legacy learned through colonialism and oppression: “The residential school system leaves our people with a long legacy, a legacy of dysfunction that spans generations” (p.15). Beth Brant, self-described Mohawk lesbian, speaks of homophobia as “the eldest son of racism” (1994, p.17). Two-spirit participants depicted how shifts in First Nations cultural views, as a result of colonization, directly impacted the healing journey:

A part of it, too, in terms of accessing services even in my traditional life – that was accessing healing components for me like the sweat lodge and different things. But when you’re shunned and barred because of who you are it’s hard to access those things that have been helping you all your life. I still feel a bit like that because I don’t know who to trust. And the men have been made to follow a dominant patriarchal way, a Western colonizer way, and so things have really changed over the years. It’s not like it used to be where it used to be more the women make the big decisions. (Isabel)

The way I was raised - my family was very homophobic - we never talked about anyone who was queer or gay. There were always racist and homophobic jokes, and so I was raised to believe that you find a man, you get married, have kids. And it wasn’t until my head started getting clear [during the process of receiving support for problematic substance use] it was like wow this isn’t working for me, this doesn’t fit. (Jamie)

Due to the multigenerational abuses, humiliation, and systematic dismantling of First Nations families and communities by the residential school travesty, many First Nations survivors and their descendents have turned to alcohol and other drugs as a way to cope with dislocation (Alexander, 2001). However, many First Nations communities are returning to traditional ways and creating new traditions, the essence of which colonizers sought to decimate.

As First Nations peoples are returning to their traditions, two-spirit people are also being accepted into their culture (Lerat, 2004). Isabel explains:

I call it “Christian hangover” or baggage that's brainwashed our people ... There's so much work to do in our own communities and just the healing part of our spirit first of all, for all people. Now they are starting to see that two-spirit people have always been a valued part of the tribes, and an essential part.

Isabel highlights the ongoing challenge two-spirit people face in claiming and re-claiming their heritage. A history of two-spirit identity does exist in some First Nations cultures, yet the struggle faced is overcoming what colonization has done to erase – or attempt to erase – that rich legacy.

*Two-spirit* as an umbrella identity label was first coined in 1990 during the third Native American and First Nations gay and lesbian conference in Winnipeg (Jacobs, Thomas, & Lang, 1997). Beth Brant (1994) speaks of these early conferences of two-spirit people:

On our separate, yet communal journey, we have learned that a hegemonic gay and lesbian movement cannot encompass our complicated history ... [Nor can it] give us tools to heal our broken Nations. ... Balance will keep us whole. To be a First Nations Two-Spirit means to be on a path that won't be blocked by anyone or anything (p.45).

A research respondent also spoke about participation in these conferences. Isabel fervently described how this involvement played such a vital role in both healing from problematic substance use, and understanding that gender need not be binary or immutable:

Being part of the two-spirit international gatherings I've been attending since 1988 - the first one. Now it's been going every year. I learned a lot from my elders and things like that so I understood; I knew that there was solidity within me in terms of genders. And it's more than one; it's more than two. So I understood those teachings and things I was taught from people who were two-spirit from the day they were born you know, and raised that way. So my goodness, to meet people like that who have not been messed with by the colonizers or the churches! A lot of my elders are very inspirational.

The term two-spirit is indigenously defined and is not intended to mark a new category of gender. “Two-spirit reflects the range of sexuality and gender identity derived from spiritual contemplation of one’s place on this earth, this contemplation shored up by the teachings from parents and elders about how to live as a two-spirit person” (Jacobs & Thomas, 1999, p.4). Jamie describes how exploration of two-spirit identity performed as a pivotal tool in a process of self-acceptance and freedom from understanding gender solely through a binary lens:

There was a point in my recovery where I went to a transgender meeting and the story that [was] shared was very emotional for me because it felt like it was my story too. Same thing happened first time I went to twelve-step programs. Those were people I could identify with. And basically his story was he was born as “Barb”, grew up as a little girl, went through adolescence and dated, got married, had a child, and then around twenty-five or so - mid twenty-five - realized that he was in the wrong body. And so over time went through the full transition reassignment surgery, so is now “Bob.” So as he was telling that story, it’s like I cried and I felt like that was me. There were a lot of times when I felt like I was in the wrong body. And this [exploration of two-spirit identity] gave me permission to look at it.

The Eurocentric gender binary system was not reflected in many traditional First Nations cultures. Several tribes had multi-gendered systems, some as many as seven genders to describe some of the many potentialities available within the vast spectrum of gender identities and sexual orientations (Le Duigou, 2000). Researchers have identified more than two hundred tribes with names and roles for two-spirit people, those who combined both male and female traits (Brown, 1994). Many cultures viewed two-spirit people as “twice blessed” (D. Grady, personal communications, 2004, shared with permission), and some were placed in the role of spiritual advisor, having a gift of vision that went beyond most people’s abilities. Certain tribes saw two-spirit people as mediators because it was believed they understood both sides of issues that arose between men and women. Two-

spirit people were not only considered normal, but also a vital and much needed part of the community as a whole.

In First Nations cultural teaching I identify as two-spirited, which I really like ... two-spirited people have both male and female characteristics and energy and features. So kind of the androgynous kind of thing, which is very fitting. And historically they have a place in the community. Typically they were marriage counsellors, mediators; they had very special tasks. (Jamie)

Isabel speaks of the challenge of living in the traditional sense as a two-spirit person, yet opts to resist “normalizing” practices despite inherent difficulty:

Being a two-spirit - also being at that time perhaps a butch dyke - I often felt ashamed about that, like I can't help how I look, but I would get discriminated against quite a bit or someone would just want to pick a fight with me on the street... My granny always told me, “You know, my girl” - she knew I was two-spirit since I was born - she said, “Your road is a long, hard one but it's also a very lonely one.” So her words mean a lot to me as I go, and it helps me to feel more balanced even though I feel lonesome or I know this journey is a hard one as a traditional person.

Isabel has described experiencing the isolating and alienating effects of discrimination, clearly demonstrating the intersection of race and gender.

Although the impact of colonization has left a legacy of homophobia, the concomitant discrimination and intolerance is lessening through a return to old ways of accepting difference. Two-spirit people are struggling to become empowered and develop community where safety and acceptance lead to healthy living.

Even within our own societies there's been discrimination. It took four years for my elder - she's my grandmother - to realize that other people tricked her into thinking women who are with women or men who are with men are evil. So she was brainwashed. People who want status and power - even within those societies - will do anything to push out the two-spirit people or the gifted people or the healers. It's not unlike anything in regular society. I mean you know we go through power and status. ... Anyways so that was a bit of my discrimination and homophobia within my own communities and it's still happening. (Isabel)

The words of participants illustrate that, despite a legacy of homophobia that is endemic to colonization, lessons may be learned from two-spirit individuals resisting oppression and forging a healing journey that incorporates a reclaimed and renewed legacy of their ancestors. By highlighting the voices of two-spirit respondents, I seek to demonstrate the interlocking nature of oppression where race, colonization, gender and sexuality entwine. Discrimination that is interwoven in race, colonization, gender and sex manifests in distinct ways as the words of Isabel and Jamie attest. Yet the voices of these two-spirit participants demonstrate that resistance does find a home in their lived experience as they carve paths of healing through complex systemic and multi-generational oppression.

## Chapter 5

### FINDINGS: SUPPORT

*Finding gay/lesbian/bi/trans/ friendly counsellors has been helpful. Gay meetings, you know, or I say queer, which covers all for me. Finding my own people, being with my own people has been the biggest support I've got so far. Where I can be who I am and I don't have to concern myself with other people's judgments or being talked about or I don't have to carry that shame, if you will. I don't know if shame is the right word, but fear. So, I think that's the biggest thing for me so far. (Nicki)*

*I have support from a higher power and from my steps and from people that I've met being clean who don't really participate in getting loaded and are not really interested in those things. (Angie)*

#### **What is support?**

Coming to an understanding of what the notion of *support* actually signified for participants was a process of coming to understand both the heart and purpose of this research. In coding the major theme of support I assembled approximately forty pages of potentially useable data from the interviews. Due to the volume of data, the quotations I have chosen to include are sometimes representative of sentiments expressed by several participants. At other times the account of a respondent offers a distinct view, and is thus included because such a perspective may not be captured by the voice of another. The quotes at the beginning of this chapter provide an introduction to what became evident as key concepts of support for a cross-section of participants. Accordingly, the data are categorized into an initial sub-theme of *what is support*, in which the concept of support is discussed as deriving from: key individuals; self-help groups; service providers and professional services. Three succeeding subthemes identify: *barriers* to receiving support (and stories of experiences that contrast with these views); the importance of *connecting with queer-identified individuals and community*; and finally a collective *vision of*

*support*. The latter segment will largely be utilized to inform recommendations surfacing through this study.

### ***Significant individuals***

Participants often referred to the significance of individuals, friends, and family members in both obtaining initial support and achieving sustained support for problematic drug use issues.

Support is just somebody who's in your life who understands who you are, you know, where you're coming from, who accepts you, and can direct you. (Nicki)

I guess first and foremost is [Pauses] having some sort of faith in something other than your own self [Chuckles]. And that may be getting together with friends and going for dinner or going for coffee with people. To me support is those around you who can be a positive influence on you and you on them. (Isabel)

Jamie provides an interesting example of how a single seemingly insignificant interaction with an individual might offer impetus for change:

One of the things that helped me turn my life around was one of the last times I used on the street in Vancouver. I wasn't living down there [Downtown Eastside] but I'd spend two or three days at a time and I was getting to that place. And one of the addicts on the street told me if I've made it this far I'm going to be a lifer. And that ended up being the last time I used on the street. I just said no I'm not. It was that comment that gave me the motivation to start making the changes. And I did. I hold that in my heart because it gave me the motivation to change. Of all the other things that people ever said to me, you know, "I can't watch you kill yourself," and all of this stuff - that didn't get through, but what he said did.

After several years in what Jamie (and many other participants) terms *recovery*<sup>12</sup> from problematic drug use, one single individual again offers motivation, this time for sustaining change:

There have also been times where I've been tempted. You know, I was out at a dry dance and then went to a club on the way home, found myself in the line-up

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<sup>12</sup> The section on *harm reduction* in Chapter 1 introduced the idea that *recovery* is a dominant paradigm in the drug treatment field, incorporating abstinence from *certain types of drug use*, and participation in self-help support groups. It may be noted that individuals participating in the recovery movement *may* continue to consume certain psychoactive substances – such as caffeine, nicotine, and legally prescribed drugs.

and its like was I really getting bottled water or thinking of something else? And so when I tell her [daughter] the next day that I came close to almost picking up again and how would you feel about that, she said: "Mom if you ever do I will be mad." And it's great, she has a voice, and I need to hear that 'cause then I carry it in my head and my heart. So if I ever put myself in a potentially risky, dangerous situation for my recovery, you know I carry her voice with me. So it's like no, I've come too far in my recovery, and in my sexuality.

Thus, the participants highlight how support and illumination about one's own substance use is communicated in unexpected ways and in unexpected spaces, often through simple connections with other people.

The messages from these next two participants encapsulate what several respondents alluded to when describing the essence of quality support from individuals: non-judgment, and a willingness to simply listen.

Sher: What works for you in receiving support from your friends? What is it that makes it supportive?

A willingness to listen; not making judgment calls, or saying you did this because of this, like trying to put a reason on it. When you're not ready to come off of it, like when you're not at that point yet, I mean you don't want someone that's going to be like, "oh that's okay you just keep doing it." But you don't want someone who's like, "that's terrible; I can't believe you're doing that to your body." I find it helps to talk to friends who have had issues in the past as well, and who sort of understand where you're coming from and the issues that you are dealing with in terms of trying to get out of something. (Shane)

Having private one-on-one counselling was helpful. It wasn't very frequent but it was good ... And with another female who was - I didn't feel judged at all about my sexuality or anything like that. She's not gay but it didn't seem to matter to me. She felt very open ... (Lexie)

Kit recalls that her introduction to conventional and available supports stemmed from a long-term relationship with a key individual.

I was with this woman for three years and she spent the whole three years trying to rescue me from my addiction. And it was really sad because she loved me a lot. I loved her a lot, but I couldn't get past the dope and our whole relationship was about her trying to rescue me. I just remembered this recently - in her trying to rescue me she had turned me on to [name] Clinic, which was an alcohol and drug

clinic, and I had my first taste of recovery then. I didn't get clean, but I, for the first time ever, knew there were resources out there.

The participant refers to a lack of knowledge that helping services existed for drug use problems. This was not a unique response, though it surprised me as the researcher.

Perhaps because of my personal history and professional involvement in the area of drug use/addictions, I had incorrectly assumed that the existence of basic drug treatment programs and self-help groups (such as AA and NA) was common knowledge. Other researchers have noted this phenomenon, and it speaks to the failure of drug services to reach marginalized populations (Boyd, 2008). Further on in this theme, participants offer suggestions as to how information could be better disseminated so that marginalized peoples who are struggling with problematic drug use might access existing services, even those services that maintain the heteronormative status quo.

### ***Treatment programs / groups / service providers***

Eight of nine participants had prior experience with accessing, or attempting to access, support from formal drug treatment services and/or self-help groups. Danielle illustrates how a bond with one particular service provider proved foundational to connecting with fundamental supports, particularly financial support and safe housing.

The counsellor that I spoke to got me into a couple of different programs. And those services are free there, which also would have been a huge hurdle for me ... wouldn't have been able to do any of it if it had cost anything. I went on medical EI. ... There was no way I would have been able to have a job. And if I hadn't of had that income it would have been pretty devastating, so I was lucky in that way. I had the support in the means that I had something financial to live on. I could pay my rent and buy food and pay my bills and not worry about getting evicted or not having housing or that kind of thing. I think that's also hugely essential. Like, you can't even begin to deal with addiction issues I don't think, unless you have somewhere to live. Like, I think that's pretty basic ... and somewhere safe, safe housing because you need to have a safe environment to have that. Anything you're going to be going through or dealing with, you need somewhere safe to have that happen ... I used to have horrible night terrors and I felt safe here. I felt

like I could lock the door. It was all women in the building. I was in a safe space so it made it really instrumental in being able to just deal with what was gonna come from [abstinence from] the alcohol.

For Jamie, who had attended three treatment centres in total, one in particular accommodated her needs because of its family inclusion. This participant was able to attend the program *with* her child and partner (at the time). Substance abuse treatment stemming from work that is being done in New Zealand demonstrates that family involvement is a key to efficacy (Matua Raki, 2009; NCAT New Zealand, 2008).

I went to one for drug and alcohol when I was three months clean. It was a family treatment centre. So my daughter came and my partner at the time came. So that helped me.

Sher: You were able to bring your daughter?

It was a family treatment program. So you are in group during the day while the kids are in child minding and then you have the rest - like from three in the afternoon you're as a family. (Jamie)

In the regions where research participants were recruited for my study (Vancouver Island/Lower Mainland of BC), there are some family-inclusive residential treatment programs that I have become aware of through consultation with a local service provider who has extensive experience supporting families impacted by problematic drug use (G. Harper, personal communication, March 31, 2010). Options for entire families are limited, however. On northern Vancouver Island there is a residential treatment centre for First Nations peoples that accept couples. There is at least one other Aboriginal-only facility on Vancouver Island that accepts the entire family. In the Lower Mainland, there is a non-Aboriginal specific centre that welcomes mothers with their pre-school age children and offers licensed childcare on-site. Additionally, I have heard through anecdotal sources that some residential programs offer specific segments or time periods

when the partner/family of affected love ones may attend and participate in specific programming.

Because Jamie was able to attend treatment with her family, she states that there was an accommodation of her needs that had not been met in her previous two visits to residential treatment. This brings up another important point. Because of heteronormative assumptions, it may be supposed that queer women do not have children, or have not been (or are not) in heterosexual partnerships – at least at some point in their lives. Jamie clearly demonstrates that the support needs of queer women who experience problematic substance use include recognition of family, in many shapes and forms.

As was mentioned earlier, all but one respondent noted that they had accessed self-help groups for support. Participants referred to several types of groups: 16-step; 12-step Narcotics Anonymous; 12-step Alcoholics Anonymous; both gendered and co-ed groups.

I started going to twelve-step programs. I needed to feel my feelings. I needed to learn how to feel them and get through them as opposed to run from them. I started making positive changes ... Going to twelve step programs - both AA and NA - I learned that I have another family outside of my biological family. So really got involved with both programs and started meeting other people who were like me and wouldn't judge me and I could phone them at any time. (Jamie)

I was staying clean and sober simply on fellowship alone ... [A friend] and I were keeping each other sober, giving each other support more than anything. We did a lot of service work and stuff like that; we were just out there, we were busy being social AAer's, but certainly not working a program. But it got me there. (Kit)

Both Jamie and Kit describe a sentiment echoed by several participants: success of the self-help programs is due, at least in part, to the *fellowship* it offers with other people who are experiencing similar challenges. This claim is supported in the literature concerning efficacy of 12-step and other self-help groups (Moos, 2008).

A gendered format was noted to be an important component in both the formal and self-help group settings. Lexie gives examples of why it is significant for her to access groups that recognize the distinct needs of women:

Once a week we would split into gendered groups [refers to a program offered by regional alcohol and drug services], which to me was like the oasis.

Sher: So gendered groups were helpful?

Totally. And that's what I go to now. I go to a women's support group on Tuesday nights and Thursday afternoons. I found with the men in the room we'd have to - a lot of times we would be dealing with aggressive behaviour, which triggers me from violence ... It was much nicer to be in the gendered groups. And women would also get more of a chance to talk; as opposed to men tend to dominate groups. Especially some of the quieter women that wouldn't always talk. And we could talk about ... I don't even know how it would be different - the topics - but it just *felt* different. (Lexie)

As was referred to in the introduction of the thesis, programming in the substance use treatment field increasingly recognizes the need for services that are tailored to the gender-specific needs of individuals (Dell & Poole, 2009; Grella, 2008; Sutherland, Cook, Stetina & Hernandez, 2009). Isabel describes a 12-step program that makes a difference to her because it seems to foreground gendered support rather than a dogmatic belief system.

I do attend a woman's AA group every Tuesday. You know, I had a really bad taste in my mouth with AA models in the past. This group is different and it's helping me.

Sher: How is it different?

It's different because ... they use candles [Laughter]. I mean they make it more calming and inviting. And it's not always the male-dominated, you know, "You have to believe in god." That's what kind of threw me off. But if I switch it to my own beliefs I just make it work for myself. So that's my ability to stop drinking right now. (Isabel)

Danielle echoes the sentiment of other participants that gendered groups afford an element of safety for women who have a history of trauma due to male-perpetrated violence, and the significance of spaces that are not male-dominated or patriarchal. In addition, she makes reference to the centrality in her life of a meeting that both includes, and is inclusive of, queer-identified women.

When I first sobered up I was really encouraged to go to AA. I didn't always feel safe in all the meetings ... just for my own personal self because of my history and my past experience. I didn't feel safe divulging personal information about myself in a group where there were men who were strangers that I didn't know. So now I found this wonderful meeting – it's a women's meeting. Probably about half the women identify as queer women. I feel safe to go there ... the other half know that the other half identify as queer, so it's very, it's open, and it's very also open to people that identify as drug addicts who might not have alcoholism being an issue.

The quotes above describe how individuals, programs, and services provide support, particularly those that allow for the differing needs of queer women or that offer an inviting space for queer women. In this next section the words of participants speak to a further common trajectory: the importance of connecting directly with queer-identified individuals and community in receiving support for problematic substance use.

### ***Connecting with queer-identified individuals and community***

In Chapter 3, I discussed the vital role community plays in the resistance of marginalized peoples. This next segment documents the experiences of participants who sought or found support in their connection with other queer-identified peoples, and how they forged community as a result. At times that took the form of friendships with *individuals and families*:

A couple days ago I sat down with one of my friends who used to do a lot of cocaine before I met him. But we sat down and had a long talk about it, and what issues I've been finding myself dealing with recently, having stopped using it. And there have been other friends who have helped out.

S: Mostly queer friends?

Yes. Exclusively, actually. (Shane)

Since coming out I've met many gay people in recovery, both male and female, and same sex families with children, and it's been great. (Jamie)

Several participants considered groups that were identified as queer inclusive, or attended by queer-identified people, an essential element of support. Once again, the theme of connecting with non-exclusively heterosexual community resonates throughout the data:

There are queer women in AA ... I found other queer women who are out there who are dealing with their alcohol addictions. A lot of them, too, have identified with drug addiction. ... I find that more supportive than any counsellor or anyone that I've gone to see. They know what you're going through – someone that has walked the same path is a huge support. (Danielle)

... Gay AA and gay NA, although there's very few gay NA because it's a newer twelve-step, not quite as old as the AA. So, you know, having that support - I can go to those meetings and feel relatively accepted ... (Nicki)

As some responses note, the groups did not need to be queer-*exclusive* to provide an environment of community connection for people who were non-heterosexually identified:

I actually just met a new friend there who's also a lesbian - same age as me, same drug of choice as me - and so we've bonded and so it's nice. We're really supporting each other. We talk daily, it's like that to me is the kind of support that they say you get in AA. Well I'm getting it in this group without having to do the twelve-step ... There are at least three, maybe four of us that come on a fairly regular basis ... Gay women, lesbians. And it's nice that they are identifying themselves as out. (Lexie)

For some participants, groups that were queer-exclusive were found to afford a connection to queer community in general:

I tried twenty years ago when I was in gay society to go to AA. I realized I was just fooling myself. I didn't want to quit. I started showing up to the meetings stoned. I just wanted to be with more gay people ... (Maria)

And in reverse sequence, this participant found drug use-specific support from a non-substance use exclusive support group:

I found an F to M [female to male] meeting ... I found out, through the F to M community, that there are counsellors that work with trans people in alcohol and drug ... my counsellor, the one I have now, her name came up as well as somebody who works with trans people. So I just happened to find her myself. So I'm just now starting to build my support. (Nicki)

This last example shows how Nicki discovered support for problematic substance use issues from *service providers* working with the queer communities. In addition, Nicki came to know that the counsellor was herself queer identified. This was an important form of support recognized by several respondents. The importance of having access to queer-identified counsellors was found to be a primary theme in treatment satisfaction in the Matthews et al. (2006) study, which assessed gay and lesbian clients' satisfaction with their historical supports for problematic drug use. In an echo of these findings, Nicki and other participants express positive experiences working with queer-identified counsellors:

She *was* my support network. There was nobody else ... I didn't have a support network, put it that way. I just assumed that she was, you know, lesbian. I didn't know, but I kind of thought - I had a pretty good hunch ... [Laughing]. I could talk more freely with her about my relationships - the issues - because there *are* different issues. It's not the same ... I needed to be okay with who I was and free to talk about whatever it is I needed to talk about. And she was that person for me, so I clung to her really, because there was nothing else. How do I sit there and talk about my trans issues with a heterosexual straight woman who's eight months pregnant? [Laughs about past experience] You know, it just made me feel more of a freak or whatever than anything. So yeah [Lesbian counsellor], she made it a lot easier. I could discuss everything with her. There's nothing I haven't told her. (Nicki)

Finally, for the first time in my life, I feel like I'm being *heard*. And someone who is a two-spirit counsellor! ... Someone who's been through that road can really be more effective than other folks who may not have that knowledge first hand. None of the traditional Western counselling models or treatment or services has helped me at all. It's been more of a detriment sometimes. So I'm just grateful

that they're starting to have services that match the needs of the people. (Isabel)

I mean now at least I can relate. Now at least I can speak honestly. Whereas before, half of the problems I talk to her about now I wouldn't have ever discussed. Same with the A&D [alcohol & drug] counsellor. Some of the stuff I discuss now is great for me because now I feel like I *can* share openly. And stuff *is* coming out that I didn't even think, because I had it down so long, trying to fit in sort of thing. And now that I know she's gay, I feel wonderful being able to share that. (Maria)

The quotations illustrate why participants found it supportive to connect with service providers who themselves were queer-identified: experiential knowledge of issues distinct to queer peoples; a feeling of freedom to speak freely; and an assumption of non-judgment owing to a shared standpoint.

There was a woman that works at the clinic who identifies as a queer woman and in the regards that she made sure there were rainbow flags at the front desk. Like a rainbow sticker at the front desk. And she also made sure there is one on her door.

Sher: And you found that helpful because you recognized it?

Yeah, when I walked in and it said this is a queer-friendly environment I went, Oh, thank god I'm welcome here. And it's so simple right? It's so simple.

Sher: In terms of making a difference to you? It was so simple but it made ...

Oh it made a world of difference. Oh, it was hugely profound, hugely profound, because I think, um, it's a terrifying office to walk in to ... I felt intimidated. I felt overwhelmed. I felt like full of shame, like having to even go there in the first place. I was just devastated. And to walk in and have it say: this is a queer friendly environment. I just went, Oh, thank god. It's not another hurdle ... (Danielle)

Danielle illustrates through her example how a queer-inclusive setting proved vital in laying the foundation for her experience of support. A queer-inclusive atmosphere may also be found in the company of heterosexually-identified women:

The support? It's women. It's all women. We all get a chance to talk, and it's done in a very respectful manner. It's all "I" statements and you only get feedback if you give permission to get it ... It's a really lovely group. And there's sort of a

group of us that come pretty regularly. And I'm glad there are straight women in there too. I've really gained a lot by listening to them. I just wouldn't just only want to go to queer groups. I mean there's a lot to be gained from these other women's experiences too. (Lexie)

Another participant agreed that exclusively queer groups were not always necessary in the drug treatment milieu, depending on context. Maria offers an explanation for why this may not be an optimal scenario in this particular instance:

I went to [names Lower Mainland treatment centre], which was awesome. And they keep trying to start up a program for gay women and for gay men. And I refused it because I felt it was exclusionary. You know, if there had been a bunch of [gay] women there I would have said yes in a minute, but because there's only two in a group - two maybe three - I don't want to be separated from the rest of the other forty people there in my own little group.

Maria appears to struggle with negotiating a sense of *belonging* – and which community to choose. In this instance, Maria questions if there would there be enough representation to create viability for a distinct group of queer participants. Maria decides that to join a smaller group of gays within the treatment milieu would deny her the benefits of larger community in the treatment centre as a whole. She foregrounds the issue of individuals perhaps having to *choose* community based on, in this case, the small number of people that may attend an exclusively queer sub-group. This particular treatment centre wants to offer options/specialized services for queer participants, though this may be taken up in unexpected ways as Maria's testimony demonstrates.

### ***Barriers***

One of the questions asked during the interview process referred to barriers to receiving support, in particular barriers related to sexual identity. I felt this was important to ask because responses may offer up clues to providing accessible support to queer-identified persons. At times participants also provided insights on this issue when not

asked the question directly. They, too, are included within this subtheme. Such is the case when Maria speaks to her experience of internalized homophobia, and the interlocking nature of oppression:

Shame. So you carry that shame. You carry that melody. I can only speak for myself - maybe I'm putting that on myself. And I'm sure I am to some point. I've been scared to access a lot of resources just because I am gay. You know, I have a hard enough time being accepted without that extra label.

Regarding institutional supports, several participants noted challenges. Nicki observes barriers with multiple health and social services in navigating a path to receiving help for substance use issues. In addition to encountering a seeming lack of awareness of sexual identity issues, Nicki cites a shuffling around of individuals whose issues are compounded by what is considered a mental health component or concurrent disorder. As was discussed in Chapter 3, a gender identity that does not correspond to that of biological sex may fulfill the criteria for *gender identity disorder* as categorized in the DSM-IV (1994), thus falling under the reaches of mental health services. Addiction, or *substance use disorder*, may not be viewed or treated as a bona fide health issue by some in the medical field (Chandler, Fletcher & Volkow, 2009), despite the fact that it must be recognized as such for individuals to access financial support for short or long-term disability. Nicki describes several vectors of complexity in accessing support:

I'd been trying for three years to get some support with my transgender issues ... I was sent to this counsellor through my insurance company. Basically [she] re-traumatized me, and I never went back. I actually have a letter from her saying so. She admitted that she did me more harm than good. And just being bounced around ... My GP won't accept my trans stuff. She absolutely won't go there. And a lot of times too, if I was sent to a psychiatrist, [they] won't work with you if you are using drugs and alcohol. So, you know I just kept on going, trying to make my way in the world. I don't have the support of my GP. Absolutely do not. Even when I applied for my long-term [disability benefits] she didn't want to put down addictions, and I had to convince her to put it down, because I'm like, this is *so* an issue. (Nicki)

Another respondent stated that they had never sought out formal or professional support for problematic drug use issues. Once again, a lack of knowledge and awareness of queer issues among practitioners is suggested as a barrier. Responding to a comment made earlier in the interview, I queried:

Sher: Because you haven't sought out specific supports or formal supports, maybe I can ask if something has held you back from that?

Don't know exactly. [Pauses] Partially just a feeling that I have enough support in my personal life to get through things without going that route. Beyond that, I guess just, and this isn't directly related to support groups, but I mean whenever those issues have come up with professionals in terms of doctors and stuff - which of course it sometimes does when you are discussing health with your doctor - I find that the attitude is very negative and not very understanding and quite judgmental. And I guess I probably have a bit of avoidance towards authority figures when it comes to those sorts of issues because of those attitudes that I've encountered in other venues.

Sher: Does the response that you've gotten from health care professionals hinder you in accessing other kinds of support like say for substance use issues?

Yeah, it's just created a general distrust of medical authorities and those kinds of things. Anger. Feelings of being sort of distanced and outside of the issues that they consider worthy of recognition. (Shane)

Research shows that addictions treatment providers lack knowledge of, or are disinclined to attend to, the differing needs of sexual minorities (Matthews et al., 2006). For example, queer peoples face issues such as homophobia, heterosexism, and internalized homophobia. The participants in the Matthews et al. study make clear that distrust of, and judgement from, medical professions are a barrier to support. The findings of this thesis are similar. Though Shane was the only participant in my study who did not even attempt to access formal supports for problematic substance use, every other participant mentioned at least one aspect of the available supports they had accessed that created a barrier due to a heteronormative paradigm.

Participants demonstrated how the heteronormative frameworks of readily available support groups prove an obstacle. Angie names the barrier directly, and subsequently offers an explanation for why many marginalized groups and individuals may struggle to have their issues recognized:

I guess it revolves around heteronormativity, within NA or AA or whatever. And how if somebody like myself comes out of the closet and is trying to seek social support - because a lot of it really is about that [social support] in the recovery community - would have a difficult time because a lot of people aren't necessarily visible or available. What I've learned, though, is that it's all part of the nature of the beast. We live in a society that is really secular and selfish and it's like: "I'm too busy taking care of my shit to be involved." It's the classic thing with our community whether its recovery or not. You know, why it's so hard to get things done for quality rights for LGBT people because everybody's so busy working and going to school. (Angie)

A "secular and selfish" society is named as the culprit in this instance. Bruce Alexander (2001) notes that, at its roots, present-day addiction in society may be understood as a trajectory toward self-interest and away from connection with family and community, including spiritual community. An essential appeal of the self-help groups, such as Alcoholics Anonymous and Narcotics Anonymous, is the sense of *community* such groups engender. This sense of community and social belonging may provide welcome relief from the isolation and dislocation that frequently accompanies problematic drug use.

Danielle describes her journey of struggle to transform what she perceives as a heteronormative support - in this example AA - into something that is personally helpful, again largely due to the fellowship it affords:

I had the most problem with AA. Even though now I find it the most helpful in the women that I know in that program. But when I first started going, when I looked into all the history of it - I did so much research trying to figure out exactly why it was the way it was. But I think for me just because it was like founded by two guys ... that had huge egos and were raging drunks with their co-

dependent wives, that it was all very structured around men getting sober and men with these huge egos. So it was all about ego deflating and coming down a notch and, you know, sort of saying where you've gone wrong and really taking the focus on yourself and making it about what you've done to contribute to your illness ... And for me, being queer, having gone through sexual abuse, coming from a pretty messed up childhood, that part of it totally didn't work for me because the last thing I needed to do was put myself down. So for me, if anything, in the beginning that could have been a lot different for me. And I can also say it contributed to where I got to. Because I really had to like ... I really fought it. It made me fight that much harder to say I struggled with it and then I also came out on top I think by saying, no screw you, this is wrong, like this doesn't work ... I found that through AA. I found that unique little niche of people that I call my support, and I also, it was really challenging for me in the beginning because I think, I didn't need to beat myself up, I didn't need to bring my ego down, I didn't need to look at my part of it, I mean, I can do that now, today I can. But I needed to overcome a lot of shame and self-doubt and all that sort of stuff in the beginning.

Danielle demonstrates how she resists the heteronormative construction of the readily available 12-step support groups, and labours to make it meaningful despite initially viewing the support as problematic for her as a woman, as a person who has been sexually abused, and as queer-identified. Interlocking oppression is again described as one more potential barrier mentioned by several participants. Isabel was most explicit in her expression of the confluence of several factors exposed to societal bias:

Sher: Were you able to be open about your sexual identity while accessing supports for substance use problems?

No, I just felt I would be stigmatized in some way because the people I was sitting in front of were upper-class, middle-aged women – white – or men, and I just felt like I couldn't talk about: a) being aboriginal; b) being queer; and c) having an addiction. I talked about my addiction and that's about it. Nothing else. I mean I think that's why it took me three times to get the full benefits of treatment. Even though I'm self-assured and a pretty strong person I just felt like *nothing*. Helpless.

The intersectionality of oppression related to race, sexual identity, and problematic drug use clearly construct Isabel as “other”. Again and again she returned, with little result, to the existing services that do not necessarily attend to the needs of marginalized peoples.

Until services respond to the distinct needs of oppressed populations - across all difference - outcomes will continue to prove inadequate, as they did for this participant.

A lack of knowledge of what supports exist is identified as a barrier in accessing even the most basic drug use services:

Really the barrier was in me. It was in a fear of going into - not knowing what treatment was about, not having a clue. It felt like I was jumping into the lion's den. And it was before even accessing treatment. It was that process of making those attempts to go and get help. And this is something I've heard from lots of people - a very common theme ... So it's not really obvious how you get into the system for a lot of us. (Lexie)

Reinforcing points that were made earlier, this participant notes that pathways to accessing basic services are either not easily accessible or remain a mystery for many marginalized peoples. Lastly, Isabel recognizes a unique barrier in a conflict that transpires through her dual location of service provider *and* recipient of services:

I've been a professional person for 22 years; I've been a social worker ... but it's hard to seek help that way, too. You have to be careful. You know, your clients are out there ...

A study by Ziegler (2000) found that professionals who are substance-addicted and who identify as GLBT experience unique barriers to accessing services for problematic drug use. This barrier is mentioned by only one participant, though the obstacle she mentions is interesting, and it highlights a population that warrants further research. Individuals who fall within the category of healthcare service providers who experience problematic substance use are under-researched in general, and the Ziegler study highlights that queer people who fall into this group may require specialized options for support.

Several participants alluded to an observation that queer peoples are over-represented in the population of people who experience problematic substance use, *and* under-utilize available support services.

Everybody knows how much drugs and alcohol are in the gay community. Statistically they say, you know, there's more drug addiction or alcoholism in lesbians than there are heterosexual women. But they're not coming forward. People *aren't* getting help because there aren't the supports there. They don't want to sit in these groups of heterosexual people and be the odd one out and fear of being judged. And it just scares people away from going, from asking for support because that's all they have. (Nicki)

As a result of pondering the context of my research study and her participation in it, Kit wonders, where are all the queer women in the drug treatment milieu?

I have never felt the need to go seek out other gay women in recovery. It's just become really apparent to me lately that there aren't many ... I wonder why that is ... this whole interview thing made me start to think ... And if I wanted to find them where would I find them? I don't know.

Kit once again clearly states that she has not experienced barriers in accessing support:

I have never struggled being a lesbian, ever. I'm just really out there with who I am as a person. I've never *not* talked about it in a certain situations ... like meetings or recovery groups or any kind of facility. I've been with my partner for twelve years, so for twelve years I've been talking about my partner. I've never questioned that it wouldn't be okay to do that ... I guess I never got the part where people didn't find it normal. I guess I missed that part, right? I guess that I'm just so confident in it that people just don't have the opportunity to go, you know, why are you talking about this or that in this environment.

However, she does recognize that this struggle is very real for others:

I've met two women recently that are struggling. They're new in recovery and they're struggling. Not *with* their sexuality, just with being comfortable being out there in recovery. And I know that I've certainly told them about a bunch of stuff - a bunch of resources, just general resources, not even like queer specific resources, but resources they didn't know were there. I've offered to go with one of the women to meetings 'cause she's just too shy to go and she just doesn't. So I've offered to go with her and she's all worried people will look at her ... I think women aren't getting the information. I know that the women I know that I just spoke of were really appreciative and grateful to have me, a) give them some information they didn't have and b) offer to go with them places so they didn't have to feel uncomfortable. So it would be neat to see if there was that kind of a resource where women would step up and help other women out. Peer support. (Kit)

In offering proposed solutions for the dilemma of inadequate support, Kit touches on several important points. Firstly, she recognizes that the need for enhanced support exists for queer-identified peoples who struggle with drug use; secondly, she argues that the problem does not lie with *queer* identity - rather, it clearly rests with oppression; and lastly, she suggests that support may be found, in part, from those who share a similar standpoint. In this next section of the thesis, respondents provide a vision of what may be done differently to create inclusion and enhance support for queer women who experience problematic drug use.

### ***A vision of support***

The final question asked during the interview process was aimed at constructing a vision of support that would originate from the community best positioned to directly benefit from such changes. I also believe that enhanced support for the subject population may provide secondary gain for other marginalized communities, and possibly increase awareness and inclusion within society as a whole.

Because the interview took a semi-structured format, I asked the question in a variety of different ways (see Appendix A, question 7 prompts) depending on the trajectory of each individual interview and what had already been covered during the conversation. When asked, “What might an organization do to make you feel supported,” respondents suggested: changes at the institutional level; improved health and social services; implementation of (effective) policy; changes in legislation; and education on issues of diversity, particularly sexual diversity.

I think there's more that needs to be done at the university level to teach curriculum that will be inclusive of all folks and also to sensitize the first person you see there – it could be an admin. person. But if they're going to treat you badly you're never going to walk back in ... (Isabel)

In Isabel's response, her position is stated in a two-fold manner. Firstly, she implies that curriculum in postsecondary education is largely heteronormatively-based. Results of an on-line survey conducted at the University of Victoria in the fall of 2003 concluded that queer-identified students did not see their sexual identity reflected in curriculum (Knox, 2003) and are congruent with Isabel's observation. From our conversation, I inferred from the second part of her statement that she believes individuals who represent such institutions may also create inclusion from their personal approach, which may be informed by education provided by such institutions.

Several respondents spoke to a perceived need for improved health and social services.

If the services were a little bit better understanding of issues facing gay and lesbian people, and the determinants that affect us – the health determinants – and that are all the same health determinants that everybody else is measured by: it's housing, work, education, and employment, and also understanding of cultural differences. (Isabel)

Angie provides an example of an actual physical situation where funding could enhance support, and tax dollars directed toward community-building for the LGBT communities.

This is only one of many such concrete suggestions offered by this vibrant activist.

The government needs to step up to the plate ... whatever it takes to create the new LGBT centre. Give us one that doesn't have rickety old stairs and a crappy old space above some old store. That's the start ... give us a hub where people can come in with their wheelchairs, fully accessible whatever ability you are, have workshops for people, a paid staff... (Angie)

Why is it important for organizations and institutions to adopt a non-heteronormative approach? Shane states the reason clearly:

Staff or volunteers or whoever is working with these organizations - I think they should all be educated on all those issues. Not just know what gay and lesbian is but to actively understand the specific ways in which that affects people's lives

and be able to deal with that supportively. And also with trans issues especially. I think there's even less knowledge around that. You don't want to be having to go to your support person and have to sit down and explain to them what the heck transgender is.

Participants suggested changes to legislation. Increasingly, critical drug researchers, organizations and service providers are highlighting the harms of drug prohibition and proposing that currently criminalized drugs be legalized/regulated (Transform Drug Policy Foundation, 2009; Urban Health Research Initiative, 2009). Proponents note that a legal regulated drug market rather than an “illegal” market makes sense both socially and economically (Buxton, Haden, & Matthias, 2008; Boyd, 2004).

Participants support such changes:

I wish they'd stop enforcing drug laws, which are ridiculous, and spend the money on helping people get treatment. That's what they need is treatment. Because once you're treated you're better. I'm not going to my dealer anymore and I don't drink and drive anymore. You know it multiplies in so many ways. (Lexie)

My experience today is that everything should be decriminalized and that, what's the word I'm looking for? Marketed.

Sher: Like a regulated market?

Regulated yeah, regulated by the government like we do with alcohol. Regulated and decriminalized. I mean, talk about getting rid of poverty. (Angie)

Participants favoured tax dollars diverted from policing and drug enforcement to drug treatment, social, and economic supports.

In a different phrasing of the final question, I asked: “What might be helpful for you in the way of support for substance use problems?” To this query, respondents mentioned drug use specific resources and groups.

The first step is having gay and bi, trans friendly counsellors who work with that specific population of people. I think that's really important. And having you know, your own support groups. Yes there's twelve-step NA, AA, but actual recovery support groups that aren't twelve-step based, there needs to be more of

that ... We need more gay recovery support groups. Just for us, you know. And led by gay/lesbian/bi counsellors. I think that would be huge. I think you'd see a lot more people in the community coming in for support if that were there. (Nicki)

It would be nice to be able to walk into a group and know everyone's a lesbian ... And you know it wouldn't even necessarily need to be a group, but if they even once a month they could have a meeting just so we could know who each other are. It's helpful to me if I'm at an event or a dance or something and I know who the sober people are. It would be helpful just to have that kind of community connection. (Lexie)

Once again participants highlight the importance of connecting with GLBT counsellors and fellow service users in drug services. Isabel sums up a sentiment offered unanimously by participants. Distinct drug groups and services for the queer communities are needed, with drug services specifically and in society generally:

I think that having groups for two-spirit people or gay and lesbian people and transgendered, bisexual, that would be great. Whether it has to do with issues of substance use or not, whether it's a problem or not, just a place to come together where no one will shame us ... (Isabel)

Maria implies that because of the disciplinary impact of heterosexual hegemony, *assimilation* creates a barrier to even knowing or having a shared knowledge of the queer experience within services that are currently offered.

I don't know what other gay people are experiencing because we all try to meld into that heterosexual because that's what's available.

Sher: How could that change for you?

If they started opening up some more gay meetings that would be huge. That would be *huge*. If maybe they had a place that was just for gay people. You know that would be great. I mean there are enough gay addicts out there. [Laughs] (Maria)

Participants were unanimous in their recommendation that more support groups specific to the queer communities ought to be available. As it stands, queer participants allude to feeling the need to assimilate into status quo offerings, even though such groups and

services are not adequate. Within such heteronormative settings, queer people do not feel they are invited as whole persons. Thus, participants speak of only being able to be open about particular aspects of their lives that meld with heteronormativity.

Though she has not experienced barriers, Kit would provide support for others wanting to access distinct services:

The gay women I've talked to that are in recovery would *love* to see something for just gay women, but it doesn't exist. (Kit)

Danielle provides an example of what this could look like. She would like to see queer-inclusive spaces that also provide educational components focusing on the impacts of problematic substance use, family, and other interconnected issues:

What would have been so helpful [hesitation] ... maybe a program like the day program ... it was like an educational four-week program that sort of looked at everything from nutrition, to damage that alcohol does to your body, to dealing with family of origin issues, that kind of stuff. To have something along those lines for queer women, queer people specific. For me personally, I would have, I think I would have felt a lot more comfortable being who I was in that situation ... I probably would have felt a lot more comfortable looking at a lot of those issues.

The lone participant who had never accessed formal services for drug use issues makes clear that they have no intention of doing so while such supports remain heteronormatively oriented.

If I were going to access [formal drug use] support, I would probably attempt to seek out a group which specifically either catered to queers or specifically marketed itself saying that it was queer-friendly. I don't think I would want to enter into a support group that didn't actively recognize those issues. (Shane)

Inclusive *environments* were touted as vital to receiving support:

I guess it seems so simple, but going to the alcohol and drug clinic, seeing a queer flag and having a sign that says this is a queer-friendly environment. I guess because that's been my experience. I know it worked for me. I went, "Phew, okay, phew, don't even have to think about that one." Um, going into a group of women where other women are openly identifying as queer so that I know I'm

safe to say that too ... Maybe having the option of a queer counsellor if I wanted one. I don't know if that works for everybody but it's helpful to me. (Danielle)

Inclusion at the level of *individual* effort was also noted as helpful:

Be more inclusive in conversations. To acknowledge the fact that gay people have problems too. You know, like relationship problems. And to make us feel more free about openly discussing them in meetings. Like I see a lot of talk about relationships in meetings, and now people are starting to say partner, which frees it up a little more ... (Maria)

Sher: Can you imagine what a person might do to make you feel supported as opposed to an organization - a person?

Um, to me it would be just that they would have some base of shared experience. Like especially understanding what it is to be in the lesbian community. It would be helpful if that person were a lesbian active in the community. I think um as opposed to a closeted-stay-at-home-never-goes-out-and-interacts-in-the-world kind of person. I guess non-judgmental and somewhat pro-active. For me, and with a lot of addicts, the tendency is to isolate. We need help doing things for the first time. So somebody who would be interested in supporting me to try new things. At least once, you know ... it's that big scary going there by myself kind of thing that triggers all the anxiety that makes me want to use. I think that would be support. (Lexie)

Inclusion across difference *within* queer communities was recognized as lacking by one participant in particular:

Sher: What might an organization do to make you feel supported?

Not just talk about inclusivity, but do it. Have policies - deep *working* policy. I was actually a board member at [names large Canadian GLBT educational organization] ... I just saw them as mouthing the words - a lot of fairly decent policy but none of it was really working. ... A lot of disconnect: "Oh I can't really relate to you 'cause I'm not from the street" or whatever ... As far as I'm concerned it has a lot to do with somebody's inability to understand and empathize at any level with people that aren't just like them. I felt like I was anywhere else; I didn't feel like I was with my community. (Angie)

Respondents specifically tout changes to policy that create inclusive programming within health, justice, and social organizations. In addition to the implementation of concrete changes, participants suggest other ways that they feel supported. Individuals working in

the helping services may create inclusive environments by such simple gestures as posting a rainbow flag. To do such an act does not even require the support of an organization, but the impact on an individual who is reticent to connect with a helping service may be immense.

Overall, as noted in earlier sections of the thesis, a receptive, informed, non-judgmental approach was wanted. These two respondents summarize why and how such an attitude would be helpful:

Somebody who understands what I've been through and can relate and can speak freely with me on issues. 'Cause you try talking to a heterosexual counsellor about your issues but ... they've never been there. They don't know what it's like to be a minority, say, or how you are actually treated out there in the world. It's not just about your sexuality; it's about how other people in the world treat you, and different issues with your partner and stuff like that. They're not informed because they don't know. So they can empathize, but it's not the same as knowing somebody's been there, somebody's walked in your walk. (Nicki)

It would have been helpful to have an outreach worker or somebody come and say, "I will take you to the clinic and go with you and it won't be scary, and don't worry ..." I had no clue what treatment was about and what it was going to look like. And also you're scared. You're giving up - it's a big abandonment or a big letting go of something - my best friend: pot. It's like this big separation thing. I think it would have been beneficial to have some direct support. But I wouldn't even have known how to ask for it. (Lexie)

Several respondents mentioned a need for improved information dissemination.

Participants noted many times that they were not aware of existing services, even status quo, heteronormative supports.

I didn't even know these services were available to anyone, let alone queer people. So somehow reaching the queer community ... let them know that the services are available and that they're queer-friendly and that they can access them just so if they decide they want to do something they can ... And then even if you do know that it's there, if there's any chance that it's not queer-friendly, like that's such a huge barrier to getting help, right? Why would you want to go? (Danielle)

More information sharing, more inclusion, more acceptance. Definitely more information sharing. I have always lived in my gay society. And now I'm learning to sort of like live in society as a whole and be gay. But I do feel detached from my gay society. I feel like I've almost gone back in the closet in a sense ... there not being enough gay meetings where I can go and relate to other gay people and see what kind of problems they're having. (Maria)

Maria points to isolation from queer communities because recovery communities are largely heteronormatively based. This participant highlights a need for the integration of spaces that have been marginalized in order for her to receive optimal or even satisfactory support.

All respondents agreed on a common element in envisioning a world with adequate support for problematic substance use issues. One participant summarizes this shared response:

What I'd like to see - I think every community needs one - is a support group in place for whether you call it a GLBTQQ, you know, the long name, or two-spirited where it's open. ... And I think once you start a group then you ask the group members, what do you need from us? What kind of stuff, what kind of information do you want to know more about? Do you want to know more about safer sex? About HIV? Especially if there is drug use involved. You know, because then as a group it becomes empowering within themselves. They are able to have a voice and to speak up and to help it evolve into what they need it to be. Because everybody's needs are so different ... (Jamie)

Jamie foregrounds the importance of service users developing and directing their own programs and supports. At the local level, groups such as the Vancouver Area Network of Drug Users (VANDU) have long stressed the importance of user participation in drug programming and policy creation efforts (VANDU, in partnership with Canadian HIV/AIDS Legal Network, 2005). The global success of user-developed and sustained 12-step programs speaks for itself. Participants in my research articulate that they want to become a part of support service development. My research demonstrates that their knowledge could contribute in meaningful ways.

## *Chapter 6*

### *CONCLUDING REMARKS*

My aim has been to witness, record and interpret participants' subjective expertise on the topic of problematic drug use, its impact on their lives, and highlight support needs that are identified. I have also attempted to expose how systemic oppression, primarily on the basis of substance use and sexual identity, has impacted the lives of respondents in my study and how resistance occurs in various spaces and places as a response to discrimination.

The overarching conclusion reached through this study is that heteronormativity is felt to be *systemic* by queer women who experience problematic substance use. Heteronormativity is a universally experienced phenomenon seeping into virtually all aspects of participants' lives. However, the responses of participants indicate several points that may be taken up as recommendations to improve circumstances of the subject population with regard to support for substance use problems.

One key factor that resonated throughout the findings is the need for inclusive services and support programs that are unmistakably inviting for queer people. The evidence of societal inequalities resulting from homophobia and heterosexism provide clear arguments justifying the need for inclusive paradigms. Systemic oppression impacts queer women's use of substances - as evidenced by participants' contributions in this research - and therefore needs to be taken up as part of any process that seeks to offer helping services.

Support for the subject population must take into account experiences of intersecting oppressions related to race, sex, gender, and economic situation. Findings

indicate that the group studied is non-homogenous with regard to many aspects of identity, and thus support must account for the complexity of peoples experience with regard to identity factors *and* the differential treatment in society of women who use legal versus illicit drugs.

From the moment of first contact with a support service, women must not face heterosexist assumptions regarding their sexuality. This finding points to the need for inclusive policy - within and across all levels of organizations and institutions - that would subsequently guide programming and/or formation of support services. In addition, consequences related to structural oppression - such as internalized homophobia - must be considered when designing services, and opportunities to examine the impact of discrimination on queer women need to be facilitated by all staff or individuals in positions of power within these systems. The findings of this study suggest that it is not only organizations and institutions designed specifically for substance use treatment that ought to incorporate recognition of systemic oppression. Distinct support must extend throughout all health and social services, government supports and institutions, and user driven self-help groups.

My study reveals that heteronormativity contributes to the *silence* of queer women, even in drug use services that offer some level of recognition of their distinct needs related to oppression. So deeply embedded are normative attitudes and practices that such silence cannot be ended solely through anti-discrimination policies and inclusive programming. Queer people begin to learn from a very early age that their identities are “abnormal” and “deviant”. Changes to legal/civil rights, the addition of policy recognizing queer peoples and their distinct support needs, and the gradual

adaptations of social and health services toward anti-oppressive ends are definitely moves in the right direction. However, undoing oppression at a more visceral level is a very different - and perhaps far greater - undertaking. This may seem a contrary statement given the subject of my research. My aim here is not to be pessimistic, however; I am simply offering a contextual view of the complexity surrounding the topic of inclusive services for queer women.

I emphasize that inclusive policy, programming, and support paradigms do not guarantee that service users will always *perceive* the services provided as inclusive. However, strong supervision and staff who are professionally educated and trained in the specific challenges faced by queer women may increase the effectiveness of inclusive services. For example, service providers need to be well equipped to respond to homophobia and heterosexism when it arises from other practitioners or service users in the support setting. Respondents to my study also speak to the importance of the qualities of empathy and experiential understanding in service providers, which may not be virtues taught or trained into an individual. In addition, service providers would ideally examine their *own* relationship with dominance and oppression, with a particular emphasis and awareness of heterosexist bias or internalized homophobia. An understanding of key contextual differences in sexual minorities' use of alcohol and other drugs can be an asset to service provision. For example, it is important to comprehend that substance use and the bar scene, historically and contemporarily, play a pivotal role in community building for the queer populations.

Accordingly, effective prevention of problematic substance use through assisting marginalized peoples with developing alternative ways of fostering community may

result in the community becoming a site of resistance to oppression in novel ways. Again and again throughout the interviews respondents echoed the sentiment that connecting with other queer people was a vital element on their journey of accessing support for problematic substance use. Connection with both fellow service users *and* service providers who were non-heterosexually identified was highlighted, as was the importance of non-judgement and inclusive attitudes in general.

Foremost, it is vital that this research foreground the subjugated voices of queer women who are impacted by problematic drug use, as the findings suggest that their experiences have too long been silenced. This study illuminates how much further we must go in order to create and provide support for queer peoples. Services need to be inclusive, co-created and informed by those who stand to benefit from those services. In addition, education, training and curriculum need to address distinct support needs of queer peoples. As the responses of participants' evidence, heteronormativity exists in our society, has an impact on our populace, and must not be ignored in cultivating responsive policy in health and social services.

Importantly, the negative impact of drug regulation needs to be addressed, echoing respondents' calls for a legal regulated market and the diversion of tax dollars away from enforcement policies and prisons to drug treatment, social, and economic supports. It is my view that such changes will benefit society as a whole. Finally, the experiences and needs of queer peoples must be central to drug policy debates, project planning, and the creation of services. This study verifies that queer peoples are willing and able to contribute to such aims, as cogently articulated by the responses of participants in my thesis research.

Beyond the subject of concretely defined recommendations for enhancing support is another dilemma I face in concluding my thoughts on this research. Myriad oppressions exist in our societies at the systemic level. Heterosexism and homophobia are oppressions highlighted through this research, and queer peoples - my research participants among them - experience life mired in these and other interlocking factors of inequity. "Support" cannot be achieved by "simply" (this is anything but simple) changing legislation, building policy, developing treatment paradigms, and further education, though these changes are vital to redressing past harm and envisioning a brighter future. Issues relating to problematic drug use and heteronormativity are deeply complex and profoundly systemic, and it is the enormity of this that I struggle to ponder and summarize. However, participants mentioned time and again how small gestures of kindness and open-mindedness enabled them to feel supported. Beyond the desired broader systemic changes we are all, as human beings, able to extend such gestures and attitudes of openness to any *other*. This is an important finding, because it may guide each of us to perform change that is within arms reach as we move about in the world and venture to communicate amidst and across difference of all kinds.

bell hooks' writing has encouraged me to contemplate research from the margins as "a space of radical openness" (1990, p. 145) where change and social justice may occur. I consider this thesis to be both a complete study in itself and a gateway to further academic research. There are topics of study in areas of intersecting heteronormativity and drug use that remain under-examined and of interest to me. One such area - arising from a comment made by a respondent in this study - is: What is the experience (help-

seeking or help-receiving) of people in “helping” professions who occupy the location of queer and addicted?

In my field of study and practice, I recognize the importance of attending to the needs of marginalized communities, queer communities among their number. In doing this research, I strive to act against the normalizing and disciplinary practices that function as heteronormativity. The challenge I view in this work is this: How do we move beyond the place of recognition of the needs of marginalized peoples to a society in which peoples’ needs are actually *recognized*. For the moment, I will be sated with conducting research that questions hegemonic practices in our professions, learning institutions and societies, and thus cultivate new research territory in the interest of social justice for *all* people.

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## **Appendix A: INTERVIEW GUIDE**

- 1). How did you learn about this research study?**
  
- 2). What prompted you to participate in this research?**
  
- 3). How do you describe your sexual orientation/identity?**
  - **Have there been changes in this description over time?**
  
- 4). Please tell me about your relationship to drugs.**
  - \*Including alcohol, prescription drugs, legal and illegal drugs**
  
- 5). Have you accessed or ever wanted to access support for substance use related issues?**
  - **Please tell me more about your experience with that.**
  
- 6). What is “support” to you?**
  - **What sorts of thing do you find “supportive”?**
  - **Have your thoughts on this changed in the past few years?**
  
- 7). Have you experienced any difficulties in accessing support? Please describe.**
  - **Tell me about a time when you wanted to get support and didn’t. What held you back?**
  - **Have you experienced any barriers related to your sexual identity/orientation? Please describe.**
  - **Please describe how you felt about that.**

**8). Were able to be open about your sexual identity while accessing supports for substance use problems? Please describe.**

- **If yes, can you describe a specific incident?**
- **Please tell me about a time when you felt that you could not be open about your sexuality or feelings about your sexuality.**
- **Have you ever felt “silenced”?**
- **Have you ever felt “invisible”?**
- **Have you ever felt “regulated”/ “disciplined”?**
- **Can you think of a time when you “resisted”? Please describe.**

**9). Have you had an experience(s) in which you received support?**

- **Please describe what was helpful to you when you accessed support?**
- **What supports would be helpful to you?**
- **What might be helpful for you in the way of support for substance use problems?**
- **Can you imagine what a person might do to make you feel supported?**
- **What might an organization do to make you feel supported?**
- **In a perfect world, what would support for substance use problems look like for you?**

**10). Is there anything else you would like to add or ask?**

## **Appendix B: CONSENT FORM**

### **Research Study:**

#### **Challenging heteronormativity in drug policy and practice: Exploring the support needs of queer women who experience problematic substance use**

You are invited to participate in a research study entitled: *Challenging heteronormativity in drug policy and practice: Exploring the support needs of queer women who experience problematic substance use*. Sher Knox is the primary researcher in the study. This research is funded by the Social Sciences and Humanities Research Council of Canada (SSHRC).

I am a graduate student in the department of Studies in Policy and Practice at the University of Victoria. You may contact me if you have further questions: by email at [sher@uvic.ca](mailto:sher@uvic.ca); by phone at: (250) 208-1267 (cell) or (250) 389-1778. As a graduate student, I am required to conduct research as part of the requirements for the degree of Master of Arts in Human and Social Development. It is being conducted under the supervision of Dr. Susan Boyd. You may contact my supervisor at [scboyd@uvic.ca](mailto:scboyd@uvic.ca) or (250) 721-8203.

The objective of this research is to identify what self-identified queer women need in the way of support for substance use issues. In order to explore the subject of needed supports, I will elicit the experiences of queer women who self-identify as having experienced problematic substance use. The research questions will explore the social factors that may impact the lives of queer women, and subsequently interlock with their experience of substance use. The direct participation of impacted individuals through in-person interviews is essential to achieving the societally important aim of having their voices/experiences contribute to the advancement of knowledge on the subject of drug policy and support practices.

Research of this type is important because marginalized groups – the queer communities among their number - are currently and historically not well represented in social and health services policy and practice. It is vital that marginalized groups are consulted directly so that we may research the impact of social oppression on such topics as substance use, and potentially utilize the knowledge to design responsive support services. In addition, this research will make a contribution to the knowledge base. Responding to a gap in the academic literature, this research study will explore the support needs of queer women who may seek help for substance-use problems.

Potential participants for this study must be over the age of 19 years, self-identify as queer (for example: non-exclusively heterosexual; lesbian; or bisexual), and self-identify as having experienced problematic substance use.

If you agree to voluntarily participate in this research, your participation will involve an audiotaped interview with the researcher, Sher Knox. The interview will last approximately one to one and a half hours and can take place at a time and location convenient for you. This interview will consist of a series of open-ended questions, which are designed to facilitate conversation and discussion between us. Please note that the interview will include questions about the use of drugs that could include illegal drugs. Following the interview you may contact me to review your transcripts to ensure that they are accurate and reflect the information you wish to convey in your interview. If there is information you wish to clarify, or remove because of inaccuracy, we will make these changes at that time.

The potential benefits of your participation in this research include an opportunity to have your voice and life experience contribute to a thesis that will become part of the knowledge base. This research contributes vital knowledge about the support needs of queer women who experience problematic substance use. Your input makes an important contribution to society, as it ensures that individuals from marginalized groups are represented in research that may shape future policy in health/ social services.

Participation in this study may cause some inconvenience to you because of the time required to participate in the interview (1-1.5 hours approx.). If you do choose to participate, it is my hope that you find our time together useful and productive. Participation in the study is completely voluntary.

There are some potential risks to you by participating in this research. There is a chance that you may experience emotional discomfort, as I will be asking questions that relate to your sexual identity and drug use. To prevent or to deal with these risks the following steps will be taken in the unlikely event that you experience discomfort: If at any time you experience discomfort during the interview please request that the interview stop. If any question causes you discomfort, please refuse to answer. If I suspect that you are experiencing undue discomfort during the interview I will stop the interview. Please feel free to contact me for de-brief following the interview. If you would like referral to available helping services in your local area I will provide you with that information to the best of my ability.

Your participation in this research is completely voluntary. If you decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study it will be your decision whether any or all of the data that you provided in the interview may be used in the research. With your permission, this interview will be audio tape-recorded. If, during the course of the interview, you choose to withdraw, the tape recorder will be turned off. At this time, I will ask you if any or all parts of the interview may be retained as part of the research. If you do not want your interview included I will destroy the audiotape.

In terms of protecting your anonymity, only I and my supervisor will be aware of your identity; this is necessary because you will be meeting with me, the researcher, for the interview, and the supervisor is responsible for guidance throughout the research process, including recruitment and data collection.

Ensuring that all data references to your identity are removed will protect your confidentiality and the confidentiality of the data. A pseudonym will replace your name in the transcripts, and no reference will be made to place names, service/organization names, or any other specifically identifying information that you might share in the interview. Email correspondence during the recruitment process will be kept confidential; emails will be deleted as soon as the correspondence is completed. If it is necessary to keep an email, I will copy the email into a word processor file that is password protected, and delete the email itself. All transcripts will be cleaned of identifying information and kept in a separate location from the consent forms, which will be kept in a locked filing cabinet in the researcher's home office.

There are some limits to confidentiality due to the size of the sample from which participants are drawn. I will conduct up to 10 interviews for the purposes of this qualitative research study. Though names and identifying information will be removed from the transcripts, it may be possible for others to identify participants through the experiences they tell or the position from which they speak. Participants will be drawn from several locations in British Columbia, which will lessen the risk that someone could identify you. All efforts will be made to ensure the confidentiality of your information and your identity, but there is a small risk that confidentiality cannot be guaranteed. If there are any particular and long quotes in your transcript that I wish to use in the final thesis, I will contact you and seek explicit permission to include them.

It is anticipated that the results of this study will be shared with others in the following ways: this study will be written up in the form of a master's level thesis and will be distributed to a supervisory committee, staff and other students. A copy will be kept in the University of Victoria library. The thesis will be accessible online through the *Theses Canada Portal*. Results may also be used for academic and conference publications. The thesis will be accessible by participants and members of the public.

All transcripts used in this research will be cleaned of identifying information and kept in a separate location from the consent forms, which will be stored in a locked cabinet in the researcher's home office. Audiotapes from the interviews will be kept separate from consent forms as well, in another locked cabinet in the researcher's home. Electronic copies of transcriptions (which will be cleaned of identifying information) will be kept in a separate file on the researcher's personal computer. They will be stored in a password-protected folder. Audiotapes will be kept for 1 year following the interview. Consent forms will be kept until the thesis requirements are met. The researcher will keep paper and electronic copies of the transcripts for up to 5 years after completion of the thesis. Audiotapes will be erased, and then disposed of. Electronic files will be deleted. Consent forms and interview transcripts will be professionally shredded.

Individuals that may be contacted regarding this study include:

Sher Knox, Principal Researcher	sher@uvic.ca	(250) 208-1267
Dr. Susan C. Boyd, Supervisor	schoyd@uvic.ca	(250) 721-8203

In addition to being able to contact the researcher and the supervisor at the above emails and phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice-President, Research at the University of Victoria (250-472-4545) or by email at ethics@uvic.ca

- |   |     |    |
|---|-----|----|
| 1. I Agree to be interviewed by Sher Knox   | Yes | No |
| 2. I Agree to be audio-taped during this interview                                      | Yes | No |
| 3. I Agree that the data provided during the interview can be used in a master's thesis | Yes | No |

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher.

_____	_____	_____
<i>Name of Participant</i>	<i>Signature</i>	<i>Date</i>
_____	_____	_____
<i>Name of Witness</i>	<i>Signature</i>	<i>Date</i>

***A copy of this consent will be left with you, and the researcher will take a copy.***

## Appendix C: INFORMATION LETTER

### Research study

#### **Challenging heteronormativity in drug policy and practice: Exploring the support needs of queer women who experience problematic substance use**

You are invited to participate in a research study entitled: *Challenging heteronormativity in drug policy and practice: Exploring the support needs of queer women who experience problematic substance use*. The principal researcher for this study is Sher Knox. I am a graduate student in the department of Studies in Policy and Practice at the University of Victoria. As a graduate student, I am conducting this research as part of the requirement for the degree of Master of Arts in Human and Social Development.

The objective of this research is to identify what self-identified queer women need in the way of support for substance use issues. For the purposes of this study the term “queer” refers to women who are non-exclusively heterosexual (i.e. lesbian, bisexual) or whose gender identity is not the same as their biological gender (i.e. f to m, m to f). In order to explore the subject of needed supports, I will elicit the experiences of queer women who self-identify as having experienced substance use problems. The direct participation of individuals through in-person interviews is essential so that impacted populations are consulted and considered in the research process.

Research of this type is important because marginalized groups – the queer communities among their number - are currently and historically not well represented in social and health services policy and practice. It is vital that marginalized groups are consulted directly so that we may research the impact of social oppression on such topics as substance use, and potentially utilize the knowledge to design responsive support services. In addition, this research will make a contribution to the knowledge base. Responding to a gap in the academic literature this research study will explore the support needs of queer women who may seek help for substance-use problems.

Potential participants for this study must be over the age of 19 years, self-identify as non-exclusively heterosexual (i.e. bisexual, lesbian, queer) or heteronormatively-identified and self-identify as having experienced problematic substance use.

If you agree to voluntarily participate in this research, your participation will involve an audio taped interview with the researcher, Sher Knox. The interview will last approximately one to one and a half hours and can take place at a time and location convenient for you. This interview will consist of a series of open-ended questions, which are designed to facilitate conversation between us.

The potential benefits of your participation in this research include an opportunity to have your voice and life experience contribute to a thesis that will become part of the knowledge base. This research contributes vital knowledge about the support needs of queer peoples who experience problematic substance use. Your input makes an important contribution to society, as it ensures that individuals from marginalized groups are represented in research that may shape future policy in health and social services.

I would be very grateful for your participation in this study. Please contact me for further information, or to set up an interview.

Email: [sher@uvic.ca](mailto:sher@uvic.ca)

Phone: (250) 208-1267

Thank you for your interest in this research!

Sher Knox

*\* An honorarium will be provided in appreciation of participants' contribution*

Appendix D: RECRUITMENT POSTER

*Interview candidates needed for  
research study*

You are invited to participate in this  
research if:

- *you are over the age of 19*
- *you self-identify as a non-exclusively  
heterosexual woman  
(bisexual, lesbian, trans, queer...)*
- *you self-identify as having experienced  
a problem with substance use*

For further details or to arrange an interview please  
contact the researcher: Sher Knox, University of  
Victoria graduate student

Phone: (250) 208-1267

Email: [sher@uvic.ca](mailto:sher@uvic.ca)

*\*honorarium offered in appreciation of 1-1.5 hour time commitment*